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NOMINATION OF GAIL R. WILENSKY, MARTIN H. GERRY, ABRAHAM N.M. SHASHY, JR., AND PETER K. NUNEZ

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON THE

NOMINATION OF

GAIL R. WILENSKY, TO BE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION; MARTIN H. GERRY, TO BE AN ASSISTANT SECRETARY OF HEALTH AND HUMAN SERVICES; ABRAHAM N.M. SHASHY, JR., TO BE AN ASSISTANT GENERAL COUNSEL IN THE DEPARTMENT OF THE TREASURY; AND PETER K. NUNEZ, TO BE ASSISTANT SECRETARY OF THE TREASURY

JANUARY 25, 1990

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THURSDAY, JANUARY 25, 1990

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Baucus, Bradley, Pryor, Riegle, Rockefeller, Daschle, Packwood, Heinz, Durenberger, and Symms.

[The press release announcing the hearing follows:]

[Press Release No. H-1, Jan. 19, 1990]

SENATOR BENTSEN ANNOUNCES HEARING AND EXECUTIVE SESSION ON HHS AND TREASURY NOMINATIONS

WASHINGTON, D.C.—Senator Lloyd Bentsen (D., Texas), Chairman, announced Friday that the Finance Committee will hold a hearing and executive session on two Health and Human Services nominations and two Treasury nominations.

The hearing and executive session will be held on Thursday, January 25, 1990 at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building.

Gail Roggin Wilensky, who is currently President of the Division of Health Affairs for Project HOPE, has been nominated to be Administrator of the Health Care Financing Administration, and Martin H. Gerry was nominated for the position of Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

Abraham N.M. Shashy, Jr., a partner in the law firm of Jones, Day, Reavis & Pogue, was nominated to be an Assistant General Counsel in the Department of the Treasury (Chief Counsel for the Internal Revenue Service).

Peter K. Nunez, partner, law firm of Brobeck, Phleger & Harrison, in San Diego, nominated to be Assistant Secretary of the Treasury (Enforcement) Department of the Treasury.

OPENING STATEMENT OF SENATOR LLOYD BENTSEN, A U.S SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. The hearing will come to order. If you'd please cease conversation. Thank you very much.

I understand that Senator Wilson has a conflicting engagement this morning and has asked to be able to make his statement at this point.

I recognize Senator Wilson, who will introduce Mr. Peter K. Nunez.

STATEMENT OF HON. PETE WILSON, A U.S. SENATOR FROM CALIFORNIA

Senator WILSON. Thank you very much, Mr. Chairman. I am grateful for the opportunity to appear before you and grateful for your courtesy.

I am here this morning on the very pleasant duty of introducing to the committee Mr. Peter K. Nunez, who is a candidate, who is the nominee of the President, to be the Assistant Secretary of the Treasury for Enforcement.

Mr. Chairman, President Bush's selection of Pete Nunez is truly inspired. No one is more qualified by training or by sheer determination to serve in this very critical position.

As this committee knows very well, the Assistant Secretary for Enforcement oversees the Customs Service, the Secret Service and the Bureau of Alcohol, Tobacco and Firearms. And though the missions of those Agencies are different, still it all comes down to law enforcement, a job for which Pete Nunez comes superbly prepared.

He is a graduate of Duke University where he majored in political science. He served in the U.S. Naval Reserve as an officer until 1966. In 1970 he graduated cum laude from the University of San Diego School of Law. He returned to the law school as an adjunct professor in 1983. Most recently, Pete Nunez has been a partner in the litigation department of the San Diego law firm of Brobeck, Phleger & Harrison. Prior to joining that firm he served as U.S. Attorney for the Southern District of California for 6 years after serving 10 years as Assistant U.S. Attorney.

Beyond the complex and often high- profile cases that he personally prosecuted and supervised during his time as the U.S. Attorney, Pete Nunez organized and conducted training sessions for border patrol personnel on criminal law and law enforcement in the area of illegal immigration and smuggling. He also served as a core city U.S. Attorney for the Southwest Border Region Presidential Drug Task Force and was a member of the Attorney General's Economic Crime Council.

Mr. Chairman, the U.S. Attorney's Office in San Diego grew significantly during the 16 years that Pete Nunez was there, as did the city, though somewhat faster. I know that well for I was the mayor of San Diego during that time. From that perspective I am very much aware of the need not only for aggressive law enforcement in the southern district, but also skilled administration of resources that are never quite as extensive as are required to do the job.

A good administrator knows how to make the resources at hand do the job. And in an area faced with a significant drug problem—from drug smuggling into the United States to high tech smuggling out of the country, from the massive flow of illegal aliens to sophisticated fraud and money laundering—Pete Nunez did exceptionally well to meet an enormous challenge.

Mr. Chairman, I am convinced that after careful consideration of Mr. Nunez's record the committee will share my view that he is superbly well qualified to serve as the Assistant Secretary of the Treasury for Enforcement. I urge the committee to favorably report his nomination to the full Senate so that he may be very quickly confirmed.

Mr. Chairman, we often have the opportunity to introduce constituents who have been privileged to receive a nomination. In this instance, as I have indicated, the privilege is one that I feel very personally because of the fact that my city, for many years, depended not just upon a very good police department for its safety, but because of our circumstances in the Southwest corner of the United States as the largest border crossing city, I think, in the world, there was a particular challenge to the office of the U.S. Attorney, and this man did that job very, very well.

Thank you.

The CHAIRMAN. Senator Wilson, thank you very much for your comments. We are appreciative of them.

Do you have any comment, Bob?

Senator PACKWOOD. No.

The CHAIRMAN. Thank you. Senator Gramm is here, and I know his schedule is busy. He will introduce Mr. Abraham Shashy. We are pleased to have you.

STATEMENT OF HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS

Senator GRAMM. Thank you, Mr. Chairman.

Mr. Chairman, I am happy to be here today to introduce Hap Shashy and to recommend to the committee that he be approved and confirmed as Chief Counsel for the IRS.

Hap Shashy has a distinguished background. He was an honor graduate of the University of Florida. He received his law degree from the University of Florida, graduated with honors, was editor of the University of Florida Law Review, received his Masters in Tax Law at New York University School of Law. He graduated with honors with a perfect 4.0 average, was managing editor of the Tax Law Review. He has taught law in three distinguished law schools—the University of Florida, New York University School of Law and Southern Methodist University. He is a partner in Jones, Day, Reeves & Pogue, a distinguished law firm in Dallas where he specializes in taxation.

I believe that he is an excellent nominee and is imminently qualified. And while in this position he may see few people smile again, I think that we should be grateful that a person with his experience, with his background, with his qualifications, is willing to undertake this very difficult and important task and I am happy to recommend him to the committee.

The CHAIRMAN. Senator Gramm, that's a strong recommendation. I share your high opinion of the nominee, and we are very pleased to have your statement. Senator Packwood?

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Gramm.

Senator GRAMM. Thank you, Mr. Chairman.

The CHAIRMAN. Next I would like to have Ms. Gail Wilensky come forward.

Ms. Wilensky, we are delighted to have you back with us and today as the President's nominee to the position of Administrator of the Health Care Financing Administration. You really have a formidable challenge in that job.

I cannot say that I envy that role for you. Because at the Department of Health and Human Services that is a tough one. It is not going to be easy to go toe to toe with the Office of Management and Budget over budget cuts and in some of our largest entitlement programs, particularly when you will be facing the need to describe to us how those cuts are being made in the interest of good health policy.

I know my colleagues on the minority side of the committee are going to profess the wisdom of a Republican Administration in offering you the position of HCFA Administrator. And I expect that Senator Riegle will point out that even before you were discovered by the minority that you were a Michigan native and a graduate of the University of Michigan. But I have one on him. See, I get the chance to speak first.

And I intend to use that privilege to preempt him a bit by saying that I really think your nomination reflects well on the members of the Finance Committee. Because it was here that you testified again and again as an expert witness, giving us guidance when we sought it, and offering some innovative recommendations. And when the research showed evidence that change in the direction of the nation's health care system was needed, you were there to help.

Gail, I look forward to hearing your testimony today. But even more, I am pleased to see that you are going to be lending your considerable talent to the development of the President's health agenda.

I now defer to my distinguished colleague, the ranking minority member, Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. I am going to echo what the Chairman said and then phrase it slightly differently. I have been on this committee for 17 years now. And I have come to the conclusion that taxes are infinitely easier to understand than medical reimbursement. [Laughter.]

There is a certain perverse logic to the tax code that you can rationally grasp if you stick with it long enough. But our medical reimbursement, medical control, and price control systems just seem to me to be a hodge podge. Every year we seem to say, here is an emergency, pass something. Coming in today, one person said to

me, maybe this is the year for total health reform. And I said, "What is that?" I do not know. I do not envy you. I think if you were a queen and had a wand that you could wave and say, "Here is the perfect health reimbursement system," I would not know what it is. I do not know if you know what it is.

Clearly, something needs to be redressed. I do not have the answer and I hope you do.

The CHAIRMAN. Thank you.

Other members? Senator Riegle.

Senator RIEGLE. Mr. Chairman, if I may, I just want to underscore your gracious remarks earlier about this exceptionally good nomination.

We in Michigan are very proud of your background and preparation that equips you to be at the table today and about to take on these responsibilities.

I will have some questions later, but I want to say again, as others have said, I welcome your nomination and look forward to working with you.

The CHAIRMAN. Are there others that have a comment?

[No response.]

The CHAIRMAN. We are prepared to hear your statement.

STATEMENT OF GAIL R. WILENSKY, Ph.D., TO BE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

Dr. WILENSKY. Thank you very much for your kind remarks.

Mr. Chairman, I have worked with your staff to respond to some concerns that were raised by Senator Dixon. I have a letter with me that places that response in writing and I would like to have it entered into the record. We will also be sending a copy to him.

The CHAIRMAN. We will be happy to have it for the record.

Dr. WILENSKY. Thank you.

[The letter of Dr. Wilensky appears in the appendix.]

Dr. WILENSKY. Mr. Chairman and members of the committee, it is a pleasure for me to appear before you today as President Bush's nominee for Administrator of the Health Care Financing Administration. This morning I would like to share with you some of my aspirations for Medicare and Medicaid.

It was 25 years ago this year that the Medicare and Medicaid programs were signed into law. This anniversary should renew for us the charge presented to these programs in 1965—to promote access to quality health care for the most vulnerable groups in our society. Today, 34 million Medicare beneficiaries and 25 million Medicaid recipients receive necessary health care through the programs administered by HCFA. Services to these individuals will be my greatest priority as HCFA Administrator.

While I believe that the Medicare and Medicaid programs have many successes to celebrate, it will not be my job as HCFA Administrator to preside over the accomplishments of the past. As we enter the 1990's it is time to turn our energies and our resources toward the most vulnerable of our day—the poor and the uninsured. As HCFA Administrator I would direct the limited resources to benefit those who are least advantaged among us.

I support the recent legislation to expand to Medicaid coverage of pregnant women and children up to 133 percent of the poverty line. Through HCFA's maternal and infant health initiative I would also encourage States to offer Medicaid coverage to pregnant women and infants up to 185 percent of the poverty line.

As you may know, I have a personal interest in issues surrounding the uninsured. In this regard I am very pleased that Secretary Sullivan will rely on the HCFA Administrator to vice-chair a departmental task force to explore the issues of the uninsured and long-term care. These are among our most pressing national health policy concerns. I am eager to work with my colleagues within the Department, as well as with Congress, beneficiary groups, health care providers, and other industry representatives in examining these areas.

As we continue to explore these demanding issues, we must do so in a way that has a sense of seasoned caution. There are no obvious answers before us. Unlimited financial resources are not available to us. What is available, however, is our collective experience and a desire to make progress in responding to the health demands of needy Americans. I commit to you today that I will continue to explore the existing possibilities for solving these problems and to seek the counsel of the beneficiary community, provider groups, and others who would like to share in solving these issues. I hope to work with the committee and its staff as I have in other capacities in this important endeavor.

The Medicare program has matured well over the years and no doubt will continue to change in the years ahead. The greatest challenge will continue to be ensuring Medicare's financial solvency. As stewards of the trust funds we have a responsibility to spend Medicare dollars wisely and to pursue policies which give us more value for the dollars we spend. To that end, we must continue with our efforts to control the growth in Medicare expenditures, particularly Part B. I support the physician payment reform advanced by the 101st Congress and as HCFA Administrator I will look forward to guiding its implementation.

The physician payment reform debate highlighted for us the complexities and the evolving nature of American medicine today. Physicians are striving to practice quality medicine with information surrounding the efficacy of medical treatments that is often either inconsistent or inconclusive. The Department's initiative to explore the effectiveness of medical practice through outcomes research will play a key role in minimizing the uncertainty that currently characterizes much of medical decision making. I have no doubt that 25 years from now we will look back to the dawning of this initiative as a turning point in the practice of medicine. I applaud Secretary Sullivan, this committee and the many committed medical groups involved for their leadership in this important area; and I look forward to working with them in pursuing it.

Beneficiaries are also caught in the middle of our evolving medical care system. They often are confused and frustrated by the lack of coordination among the providers of care who serve them. New ways of delivering health care, such as HMO's and PPO's, can help beneficiaries coordinate their access and have great potential for enhancing quality as well.

As HCFA Administrator I hope to encourage movement away from a la carte medicine and toward coordinated care approaches. The job of HCFA Administrator requires balancing the competing demands of the many groups that HCFA serves, most especially the beneficiaries. I will do my best to serve these groups well and I look forward to their participation in addressing the issues facing our health care system as we, the Administration, and the Congress, continue to consider the health care demands of our citizens within the means available to us.

I offer you my expertise in health care, my knowledge of the Department, and my sincere and personal desire to improve the health care system in this Nation. I would be honored to usher Medicare and Medicaid into their second quarter century of service.

Thank you, Mr. Chairman. I would be pleased to answer any questions you may have.

The CHAIRMAN. Ms. Wilensky, the prospective payment system, the DRG's, are now in their seventh year and we are continuing to try to evaluate them as to equity and particularly in the differential between rural hospitals and intercity hospitals. Senator Dole, Senator Baucus and others joined together with me on the reconciliation bill in legislation to get to a single-rate system. And with it, taking into account the severity of illness of some of the patients, to try to see that those full-service hospitals are adequately compensated for a sicker patient population.

Now what steps do you intend to take to develop that proposal? When can we expect it? How do you intend to take care of that differential—the $400 million or $500 million cost of eliminating it? Are you going to consider a faster phase-in period?

I understand that the Prospective Payment Assessment Commission is about to recommend a faster one. As I recall we had it originally in 1995 and may be talking about phasing it in as early as 1993.

Now, will you go through that litany of questions for me?

Dr. WILENSKY. Yes, I would be glad to.

We have received a report that pertains to the severity of illness adjustment which has been the great concern previously to having a single rate. We are in the process of analyzing it and we will be submitting that information to the Congress in a report October 1st of 1990.

It is our sense that the earliest date that we could implement a single rate would be fiscal year 1992. That would allow us to fold in severity adjustments, and to also account for other adjustments that would need to occur so that we do not have large urban teaching hospitals unduly advantaged at the expense of some of the small rural hospitals. We feel that before fiscal year 1992 it would be impossible to phase this in. That date would allow us to make all of the adjustments needed to make sure that we do not have unintended effects.

It is the intent of the Department to propose a legislative package which would be budget neutral, although I understand that there is some concern that there is, in fact, a substantial cost to be associated with this. This is an issue that I think we will have to discuss further and work out in discussions with the committee.

The CHAIRMAN. Let me ask you, when we add a severity measure to the DRG's, are we simply going to increase the payment for more services? Does it add up to that?

Dr. WILENSKY. Well, it's—there are——

The CHAIRMAN. Or can you truly distinguish these sicker patients?

Dr. WILENSKY. That is what the question has been all along. It has been a sore point in the DRG system which is based on a system of averages. To the extent that some hospitals have consistently sicker patients, we knew that they were facing hardships. And it has been the belief in the Department, in PROPAC, and I believe in the committee, that when we had an adjustment for severity, that would allow us to go to a single rate.

I think we will have to wait until we have analyzed in greater detail this information that has been submitted to the Department to be able to convince ourselves that that is the case. But it is clearly our intent.

The CHAIRMAN. Every year we look at increasing hospital payments under the prospective payment system. We look to the Administration for counsel and advice and we look to PROPAC for guidance on that. And then at the same time we are having to take into account the deficit problem that we have in this budget.

What other factors do you think we have to take into consider? You know, the hospital administrators are always telling us that unless we increase it health care is going to suffer and it is going to deteriorate. Do you agree with that?

Dr. WILENSKY. I do not agree with it in the average. The concern has been with particular hospitals. We do take other factors into account. The other factors taken into account are some of the advances of science and technology, also some of the changes of productivity, and then in addition, changes in case mix.

The last one has been a troubling issue. We have observed increases in case mix. We think that it is partly due, in fact, to a sicker hospital population. There has been concern that it may also be due to changes in coding procedures or other changes that are not necessarily reflecting the true case mix. But the attempt is made, and should be made, to take all of these factors into account and not just our fiscal position in the budget.

The CHAIRMAN. Last year, as I recall, the OMB was recommending a cut of about $5 billion in Medicare. We did about $2.75 billion, was it not? The net, finally. Now I understand they are talking about something substantially more than that. We have not seen it yet. I see that 27 of my Republican colleagues in the Senate have asked not to do that; and I know that a great many of my colleagues on the Democratic side share the concern of what is going to happen to hospital services.

Do you have any comment concerning that?

Dr. WILENSKY. I have seen the letter and understand the concern that was expressed in it. It is hard to look at the Medicare program—the size of the dollars that it represents, the growth rate in expenditures that have been experienced, and to not regard this as an area that will come under consideration with regard to budget reduction.

The question I think we have to satisfy ourselves is that the cuts that are made are equitable and are not unduly hurting hospitals. I know that this committee, and you in particular, have had great concern about the status of rural hospitals and I think there has been a number of pieces of legislation that have been enacted to try to make sure that the rural hospitals and some other disadvantaged hospitals were not, in fact, being unduly hurt through this.

On average, I think that the amounts that have been allocated for hospitals have been all right in the past. We will have to make this decision, though, each year.

The CHAIRMAN. I see my time has expired.

Senator Packwood.

Senator PACKWOOD. Thank you, Mr. Chairman.

During the recess I conducted hearings in 11 different towns in Oregon on the subject of rural health. The largest town I was in had a population of 9,000; the smallest, probably 1,200. Each of them had a hospital.

In one of the smaller towns, if the hospital were to close, the next nearest hospital is 135 miles away. The small hospital has 25 to 30 beds. It has an average in-patient load of seven. It used to be about 15, but they are doing more out-patient work. The population of the town has not changed; they are just doing more out-patient work. But they have about seven a night in the hospital.

I discovered in the hearings that in rural areas people are disproportionately poor and disproportionately old so that these hospitals have a higher than average load of both Medicare and Medicaid patients. And secondly, they do not really have the option that an urban hospital might have of saying, "Well, we are not going to take you. Go to another hospital." There is no other hospital.

Should our policy be to try to keep hospitals open in these areas? Or should we say, "Gee, it would be nice and it would be convenient, but it is too bad. If you need to be hospitalized, you will have to go 135 miles for maybe a 2-day hospital stay or maybe a 2-week hospital stay." What should our policy be?

Dr. WILENSKY. I think the answer will depend on the available resources elsewhere. But there has been a clear commitment to try to protect the sole community hospitals. As you well know, there have been special provisions made for hospitals that represent the source of care, initially defined within a 50-mile radius, later in fact reduced to be less restrictive, to have it be a radius of 35 miles, and to pay these hospitals at the higher rate.

There are a series of programs that have been enacted, that are being implemented now—the essential access program and the primary health care access program—to also try to help some of the very small hospitals that may not be able to make it as a hospital to evolve into some other type of supportive health care facility.

Senator PACKWOOD. But if you do that, then you are saying that those who have to be hospitalized are going to be transported a significant distance.

Dr. WILENSKY. The point here is not to try to force these facilities to do that, it is to allow them, along with such things as the rural hospital transition grant program, the opportunity, if they believe there is a more viable way for them to sustain themselves, to have them some support in doing that. I think the notion of the sole

community hospital really does recognize the belief that hospitals that are the sole source of care should have a different standing. And I think there the only question you can ask is, "Are we providing enough support?" The mileage you are talking about is well within that distance obviously.

Senator PACKWOOD. That mileage clearly is.

In your judgment—let's just work backwards—should our conclusion—not premise, but conclusion be, we are going to make sure that there are hospitals available in these areas? If so, what is necessary from the Federal Government? For example, Medicare reimbursement, or tax credits for physicians who would locate there? If we say we are going to keep the hospitals, then what is necessary to keep them?

Dr. WILENSKY. Well——

Senator PACKWOOD. Assuming, of course, the area wants to keep the hospital. I understand that. But all the areas I visited wanted to keep the hospital.

Dr. WILENSKY. One of the things that I think needs to be discussed with the areas is the types of facilities that they are able to provide in their communities, again with the intent not of pushing them out, but of making sure that they understand some of the options. Depending on just how small some of the small hospitals are, questions arise as to whether full complements of services can be provided or if not, how else they can be provided.

We know that there are some kinds of facilities, some kinds of services, that require higher volume than one is likely to get in certain areas.

Senator PACKWOOD. Let me interrupt you, Gail. They are not trying to do heart transplants. They are delivering a baby at 4:00 in the afternoon, or they are scraping somebody up off the highway at 10:00 at night and bringing him into the emergency room. They have got somebody who has got a mild case of pneumonia that the doctor has hospitalized for a couple of nights. They are not trying to be full service medical centers.

The things they do do—I discovered the routine things they do do, they do pretty well; and they probably do them as well as you would get in an urban hospital. But they do not want to be Massachusetts General. They would be happy just to keep their 15 or 20 beds going. But I find their costs are disproportionately high because of a relatively fixed overhead and a very small patient load.

Dr. WILENSKY. I think that what we need to do now—your concern is very clearly expressed—is to look at the series of changes that have been introduced in the last year or two. We have a 4-percent greater differential with regard to the update for rural hospitals that is in effect for this year. We have these two new programs—the Essential Access Program and the Primary Access Program—that are just beginning to take hold. We have the Rural Transition Grant Program also assisting and we have the sole community hospital.

We need to access the combined effect of these changes. And if, in your opinion and in the Administration's opinion, we are still, with all of those steps, not doing enough, then we have to reconsider what else we need to do.

Senator PACKWOOD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Good answer.

In the order of arrival, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I want to echo your praise for Gail Wilensky. I think it is outstanding news for the health care community, and for the American people that you are being nominated to be the Administrator of the Health Care Financing Administration. I think getting a B.A., a M.A. and a Ph.D. at the University of Michigan could be, you know, a little bit of overkill, but we will overlook that.

A couple of points. One issue I want to discuss first is physician payment reform. We deliberately held off the implementation of the fee schedule until 1992 and stretched full implementation out over a 5-year period. I would hope that you would do everything possible to make sure that that physician payment reform bill is implemented as it was enacted. Second, I hope that you will affirm your determination to not open up the physician payment reform legislation.

Dr. WILENSKY. We are very sincere in our interest in trying to see that bill implemented as it is written. It is my view that HCFA must take the position that the start date, as it is written, is a date that will be met, period.

We are concerned about the amount of work that needs to happen before implementation. As we proceed through that period, we will be in consultation with the committee. And that if there are portions that we have concerns about how well we can implement, discuss what we believe that we can do as well as we can do it, and see whether there is any modification that would be appropriate to take under consideration. But we regard that 1992 date as a firm date and agree that it should not be opened up for renegotiation.

Senator ROCKEFELLER. Good.

This is a more specific matter, Dr. Wilensky. HCFA is seeking a retroactive payment from the UMW—the United Mine Workers—Trust Fund in the amount of approximately $40 million. As you may know, the UMW Health Trust Fund is currently in a very, very precarious financial position. This involves over 100,000 retired miners, and spouses, and dependents, et cetera. Are you aware that HCFA is, in fact, doing this? In fact, trying to change a formula—a longstanding formula—by which the trust fund acts as an agent for Medicare, and therefore as a Medicare payer?

It is my understanding that HCFA is disputing a longstanding formula used by HCFA to determine Medicare Part B payments at a time that the UMW Trust Health Fund is in disastrous shape. The 1950 fund is broke to the figure of $60 million or $70 million.

It is a very critical time and I am hoping that you will agree to work with me, with the UMW, and with the Bituminous Coal Operators Association, to try and address this problem before we just spring a retroactive $40 million package on them.

Dr. WILENSKY. I became aware of the general nature of the problem a short time ago. I am anxious to have a chance to understand the details more clearly. I have understood that the lawyers of both sides have been in consultation with each other. And I would cer-

tainly pledge to you that I will do a prompt review and come back with some proposed solutions.

Senator ROCKEFELLER. Thank you.

On another matter, as you know, last year psychologists became reimbursable under Medicare. That was not necessarily an easy thing, but it was done. I've been told that HCFA in writing the regulations to implement that legislation is rather narrowly interpreting Medicare coverage for psychologists. And, in fact, are saying or are potentially saying that psychologists cannot be reimbursed within a hospital setting.

You know, under current law physicians are allowed to bill for care they provide in the hospital. Potentially psychologists are not. I do not know if you are aware of this. But I would like to send you a series of questions on this and raise this red flag.

I also have a question on nursing home reform I would like to put in writing to you.

[The questions appear in the appendix.]

Senator ROCKEFELLER. My final point, I guess, would simply emphasize that the Pepper Commission, which I chair, and the similar HHS group that you are working on, and the Social Security—the Quad Commission—are incredibly important commissions. It is crucial that we all work together.

Finally, cost containment is a major problem in health care. There is no question. Everybody wants benefits. You can do outcomes research, practice guidelines, utilization reviews, all kinds of things. But essentially cost containment is very tough politically.

The President's budget will reportedly cut $5.5 billion from Medicare payments. Now that is certainly cost containment. But it is savage and I would hope that—you know, last year the President proposed a $5.5 billion cut and we managed to reduce it down to about $2.3 billion. To try to achieve the savings the President has called for, again, this year will be extremely difficult.

I expressed my displeasure with this in a letter to the President yesterday and I simply wanted to say, I think cost containment is important. But I think meat axe approaches sometimes can do more damage than good. That is an opinion. You do not need to respond to that.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Gail, thank you for your statement and for your responses, for your commitment. I would also like to thank the folks—this is sort of an incredible period of time. We have gone a better part of a year now without an Administrator. I do not know that that has ever happened before. I think it is tragic that it has happened. We all know why it has happened. But I want to thank people like Lou Hays, Guy King, Ed Moy, Tom Hoyer, Sid Treiger, and a whole lot of people at HCFA who have carried on in the absence of an Administrator.

I thank nameless, faceless bureaucrats, whatever we want to call them, people we criticize too easily. I just really think it is very important that we say thank you to those folks who never have a chance to sit where you are, other than to be criticized by all of us, for carrying on over the last year.

Secondly, I heard the Chairman of this committee today say something I do not think in 11 years I have ever heard him say. And that is, that your presence here and the President's confidence in you "reflects well on the members of the Finance Committee." I do not think I have ever heard Chairman Bentsen or his predecessors ever say that before.

I think that is not only an unusual statement but it sort of reflects the reality of how the Chairman of this committee, and I think all the members of this committee, view the role that we have all played in trying to formulate health policy over the last number of years. I think there is a significance there that is going to elude all but the best reporters sitting out there in terms of who makes health policy in this country. And the answer is, nobody and everybody, which makes you a very, very special person.

I have a couple of questions. One is specific to the implementation of physician payment reform. I have been given to understand that there is a little tension between the Physician Payment Reform Commission and HHS, over which organization is better qualified to implement physician payment reform. You were one; you are now the other. Do you have a view on the respective roles of each of those organizations in the implementation process?

Dr. WILENSKY. I think it is correct, that there has been some tension between the two organizations. That is natural. It is probably healthy. It was, I think, probably more likely to be true during the policy formulating stage; and it may be a little less true during the implementation stage. There is some concern at HCFA. I have shared this with the Physician Payment Review Commission. It was one of the advantages of sitting with a foot in both camps, so to speak. There has been some concern that the people who were so active in recommending policy have not experienced implementing such policy and do not have to worry about implementing it now.

I am sure that message was heard. I think it is important for the two groups to work together. I have pledged to the Physician Review Commission we will work well together. I think it will help that I have a longstanding knowledge and personal friendship with at least half of the members, as well as their Executive Director. I think that will do it.

Senator DURENBERGER. Terrific. Thanks.

I also have some other questions I would like to submit in writing, including one about the Safe Harbour Regulations proposed by the Inspector General's Office, that I would like some comments on.

[The questions appear in the appendix.]

Senator DURENBERGER. But I think my bottom line question, so we have some sense of the role that you may play, relates to the work that this Pepper/Rockefeller Commission is trying to do and which you have been trying to do most of your professional life, as I understand it. You articulated that well. Promoting access to medical and long-term care services for the most vulnerable among us.

The reality being that while we had 25 years of protecting 34 million folks, the number of people who do not have direct financial access into the system is growing every year. That has got to tell you there is something wrong somewhere in the system.

I do not know whether those of us on the Pepper Commission are going to come to any conclusions about varying approaches to solving the problem—if the problem is financial access for everybody, how we are going to do it. We could put $75 billion in the existing system. We could go to Canada. We could go to Massachusetts, which the Chairman has periodically recommended we at least look at. Or, we could try to fix up the existing system before we put $75 billion into it.

But in either case, one of the elements that keeps coming back—and it has been in this debate for a long enough time so that I would like to ask you about it—and that is the fact that the social insurance system in this country—is today the under girding, under earning, savings, investment and insurance. We are getting rid of welfare and the social insurance system is there to be used.

Currently that social insurance system is some kind of mix of medical assistance, Medicaid—God knows what—but a lot of money is flowing into long-term care and into care for the poor through a kind of a broken down concept of welfare.

What is your general view on whether or not we ought to—some people say federalize Medicaid. Let me put it this way. The national social insurance system ought to guarantee access to medical services for all of lower income people in this country—be their safety net, in effect—and to provide a guarantee of financial access for long-term care. What is your general view on that subject?

Dr. WILENSKY. Well, those are the issues that all three of our groups are struggling with. We want to do it. We want to reach those goals. The question is: Can we come up with strategies that will both maintain or replace a health care system with one that we prefer and do it in a fiscally prudent way. As you well know from your work before the Commission, as well as your work on the Pepper Commission, these are not easy questions to answer on it.

There are a variety of strategies and approaches that one can take and it can be expanding Medicaid at the bottom. It can be building onto our existing employment-related system. It can be scrapping that. They are hard questions about what way do we as a country want to go.

In the Department we have given ourselves a deadline of October 1990 to come up with that. You are on a shorter time line at the Pepper Commission. The Advisory Council for Social Security is between us. I think that there are a lot of choices. And as you well know, there is not any set that is going to easily come out.

Senator DURENBERGER. That is the most evasive response I have ever heard you give. I can tell you are now on the other side. That is very well done.

The CHAIRMAN. Thank you very much, Senator. We have several other Senators here and we have three other nominees.

I would like to call now on Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman. There are several groups that are working to develop a new way of providing not only universal health care access and coverage but also in the process to figure out how we really control costs better than we have been able to do so thus far. The two goals are clearly tied together.

In addition to the groups that have been mentioned we have a working group underway here in the Senate on a bipartisan basis. Many members of this committee are part of it and others not on this committee, but who have had a long history and interest in health policy. I am hopeful that within a matter of a short period of time we will be able to have a consensus view that I would hope would line up quite well with the work that the Pepper/Rockefeller Commission is doing and will give us a road map for how we really restructure the system and bring everybody under a system of health care coverage.

I am profoundly struck in reading the economic and financial news each day. Our relative performance as a nation is measured by the trade deficit and comparative interest rates and everything else. In addition to the moral imperative of having a healthy country and a healthy population, there is an economic necessity to have every citizen in the best health that we can achieve so that people are in a position to produce and contribute to the economic strength of the country.

We no longer can tolerate, whether it is educational deficiencies or job training deficiencies or other structural problems, and certainly not health care, deficiencies that hold back any significant part of our population. It cuts against our national interest and it is far more expensive to have a nation of many walking wounded, in one form or another, than it is to have a system in place that addresses our needs and puts the resources into getting our people up to strength, so that we are a fully producing nation.

And unless we can achieve that goal, then I believe there is no future for us but a backwards slide in terms of the international competitive picture that we are now facing. So we have in addition to the moral imperative, which brings you to the table and brings many of us here into public service, of trying to meet very urgent human needs, a very compelling economic necessity for the country that is now part of this discussion and part of the imperative of having to move to get everybody under a comprehensive system of health care coverage.

The idea that a single child or adult in this country should have an illness and not be in a position to afford or get adequate health care I think is something that cannot be tolerate any longer on both grounds.

So having said that, let me ask you just two or three questions that relate to other things that you touched on earlier in the day. I am very pleased that you bring the kind of expert background and knowledge to this position at this time.

Can you tell us more about the Department of Health and Human Services internal task force on the uninsured? And what kinds of specific plans do you have in your own mind for the uninsured here?

Dr. WILENSKY. The task force is headed by Connie Horner, the Under Secretary of the Department. There is a steering committee that has the Assistant Secretary for Health, the Assistant Secretary for Planning and Evaluation, the designee will be before you shortly, the Assistant Secretary for Management and Budget. I am serving as its Vice Chair.

I do not know that it originated from, but was first raised at a hearing by Dr. Sullivan at the Pepper Commission at the end of last summer, and the instruction was to take basically a year to come up with a set of strategies with regard to long-term care and the uninsured—the basic access problems that we are facing.

We are going through a process that is similar, I suspect, to the one the Pepper Commission and also the Steelman Commission is going through, of trying to make sure there is agreement on the basic facts and laying out the issues. And we have not at this date yet come to grips with the issues of how are we going to make trade-offs with regard to strategies, with regard to roles of individuals. There are some fundamental questions of the role of the employer community and of the role of Medicaid and its expansion and whether or not to maintain it in its current position.

I think that the fact that there are these very diverse groups is something whose importance we cannot overemphasize. As somebody who has worried about these issues for 10 years, that is an astounding fact in and of itself to have three groups this diverse sitting in different places worrying about these same issues.

Senator RIEGLE. How far away do you think the group is from, in a sense, reconciling as best one can the different points of view? And are you presenting a point of view yourself on the question of coverage of the uninsured?

Dr. WILENSKY. Not yet. I mean I will, but I am not yet doing that. My guess is that will not occur until early summer.

Senator RIEGLE. May I just ask one other thing, Mr. Chairman? I will be very brief about it. That is, would it be your view—and I tend to assume it is, but I want to have it on the record—that private coverage alone is not going to get this job done, that we are going to need a combination of private and some expansion of public coverage in order to really accomplish the goal of health care for all Americans.

Dr. WILENSKY. I think that is likely.

Senator RIEGLE. Is the goal of the group to include everybody in the society?

Dr. WILENSKY. We have not set out a specific goal—which commissions usually do at some point—that says these are the goals. We have not done that as a group. It is clearly to respond to the 31 million uninsured and to the problem of long-term care not being available to substantial numbers of people. But the goal of including everyone in our society has not been taken at this point. It may, however, act as a specific principal and guiding rule for the group.

Senator RIEGLE. Well I hope it will be. Because if you are going to draw a line and somebody is on one side and somebody is on the other side, I would really like to see the case made for who is left out. I would hope that you would advance that view.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Pryor.

Senator PRYOR. Yes, thank you, Mr. Chairman.

Today, it is my understanding that Medicaid in our system is the largest single purchaser, the number one customer, for prescription drugs. The other fact is that from 1981 to 1988 we have seen a 28-

percent increase in the general inflation rate. However, during the same time we have seen an 88-percent increase in the cost of prescription drugs.

Now, is there a role that you see the Federal Government playing in assisting the States in becoming a better and a more efficient purchaser of prescription drugs? If so, I would like to get your ideas on what that role is and what you plan to do about it.

Dr. WILENSKY. Let me first say that in general I am very interested in the Medicaid program, and it is my intent that Medicaid in general will take a higher priority than perhaps it has taken on the Administrator's agenda in the past. The issues of Medicaid itself are of great importance to me and I will be pursuing them.

With regard to the specific question, I know that it is an area of interest to you. It is my understanding—but I do not have a great deal of specific knowledge about it—that a few States are already attempting to act to use their power as a Medicaid purchaser to purchase in a prudent way.

What is not clear to me—and I simply have not had an opportunity to learn the specifics—is whether there is some prohibition to keep other States from doing so, whether there is a legislative problem that is not allowing States to purchase in a prudent manner their prescription drugs.

Senator PRYOR. In my understanding and studies of this issue, there is not a legislative prohibition. I do think that there is a political impediment and I think that that political impediment and obstacle is the pharmaceutical manufacturers.

For example, today let's take a medication called Lopressor, which is a high blood pressure medication. It is used very much in the Medicaid program. The Medicaid program today for Lopressor is paying $34. Hospitals and HMO's are paying a much lower amount of $28. The VA is paying $24. The VA today is buying many of the prescription drugs for let's say their clientele or those patients in the VA program for sometimes half of the price that the Medicaid program is paying.

Now I think that the pharmaceutical manufacturers have got to be brought to the bargaining table. They have got to be made a part of this process and today they are not. They have been freewheeling and they have been making exorbitant profits. This committee, I think, has been extremely generous with them on certain tax concessions and that philosophy, I assume, is to encourage them to go out and find cures for cancer and for AIDS and Altzheimers and those other dreaded diseases that we have. I am not certain they are coming up with their end of the bargain.

I strongly believe that there is a great deal the Federal Government can do and I am going to introduce legislation patterned on the practices of the private sector to force our States to bring the pharmaceutical manufacturers to the bargaining table. Now I hate the word "formularies," but we are going to use non-restrictive preferred drug lists to bring these costs under control. This is going to be a very, very major challenge and significant responsibility in your new duties.

Dr. WILENSKY. I would be happy, once confirmed, to try to talk with the States to understand what has kept them, if anything, from acting as prudent buyers, and whether that is a strategy that

they also would like to pursue. One of my interests is to try to have HCFA play a facilitating role with the States to try to help them in any innovative ways they can to provide health care.

Senator RIEGLE. Well just another little fact to chew on—and this is very curious to me—Epderpril is a Parkinson's disease medication. In Italy the citizen can go into the pharmacist and buy that same pill that is manufactured in this country for 41 cents a pill. In our country, our Medicaid program is paying approximately $2.00 for each pill. And to me this does not make sense.

I really hope that you will concentrate on this problem and that we will look forward to having communication with you on that.

Second is—Mr. Chairman, I do not have time to put my second question. But in writing I would like to propose to our very distinguished witness this morning a question relative to how we can possibly educate our elderly population on Medigap insurance policies. We have seen an escalation of prices. We have also seen a great confusion out there. I will submit, Mr. Chairman, that question in writing.

Thank you very much.

[The question appears in the appendix.]

The CHAIRMAN. Fine. Thank you, Senator Pryor. You have posed a couple of very interesting questions to her and I am going to look forward to hearing that answer.

Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you.

Ms. Wilensky, you have an outstanding background and qualifications. I know that people have asked you some very good questions about coordination among the Commissions currently working on issues of health care, long-term care and access. You and I had a discussion about that with respect to the Pepper Commission and the Administration's involvement, or up until now, perhaps understandable, a reasonable lack of involvement therewith. I will not cover that ground.

But I do want to bring to your attention an issue that I also raised with you last night—that is, the very serious situation involving people with end stage renal disease. As of February 1, because of the law passed by Congress, ESRD patients who are now receiving home dialysis will be unable to obtain any more than the Method One reimbursement, which is the clinic rate. Method Two providers—which is home dialysis—have indicated that they will not be able to afford supplying home dialysis technicians as they do now. As a result, to the extent that people are physically unable to go to clinics, are unable to care for themselves and have no assistance that would be appropriate without risking their lives, literally, to go into a dialysis clinic, those people will as of February 1 be at risk of going without treatment.

Now Secretary Sullivan, to his credit, has indicated that he is not going to let anybody fall through the cracks. But the problem is that while that may be his desire, there is no indication that his desire is being put into practice. For it to be put into practice there needs to be a case-by-case assessment and a specific plan made to care for these people who can only be cared for at home, to the best of our understanding.

Since this was a law passed by Congress we need to know first what exactly the Secretary has done and is going to do between now and February 1. Secondly, based on talking to one or two of the people in my State who cannot possibly go to the clinics, we have discovered that what they are being told, in terms of a case-by-case assessment is, you better make arrangements to solve your problem. Now that is not what any of us mean, of course, by a case-by-case assessment. That is a case-by-case disaster if that is what continues to happen between now and February 1.

Clearly, this is not what the Secretary wants or intends. But time is short. Only a few working days are left. I would appreciate either you responding to it today or having the Department respond in writing to us before the close of business today on how these problems are going to be addressed as the Secretary, to his credit, has said he intends.

Dr. WILENSKY. I will pass that on. I spoke again with people who are involved in it in the Department to try to familiarize myself after our discussion. It is an area, as I indicated, of active concern in which frequent meetings are occurring. There is one that will occur later today about your concern, as I shared with you last evening.

Attempts have been made by telephone, by writing, and for anyone not before reached, now by Certified Mail, to contact each person. It is my understanding that the number of hardship cases at the moment—although there has not been 100 percent contact as of yet—was closer to the neighborhood of 100. But there is clearly a number of people who will have to be dealt with. And the Department has once again reiterated its position that it is assuring that every patient will receive satisfactory placement for dialysis service.

But I will share your request that more specific information be provided.

Senator HEINZ. My time is about to expire. I would only emphasize that it is the content of the contact that is important. I have not heard you say anything today about whether these people are being assured that they are going to get help.

My information is to the contrary. That they are being told, "Well, there probably is nothing we can do for you. You better make your own plans." Now that puts several dozen people at risk as of February 1—of the case histories we know about.

Dr. WILENSKY. I will have that issue also addressed.

Senator HEINZ. Thank you.

The CHAIRMAN. Well, Senator, I am glad you brought the point up because I have written Secretary Sullivan on the very point. And going along with the Administration on reconciliation insofar as their directions to reduce that payment on home dialysis, on Method Two, I insisted that that be deferred, the effective date until February 1, and now ask the Secretary to tell us what steps are being taken to assure that we do get a smooth transition and that we do not have some irreparable damage resulting.

Dr. WILENSKY. It has been a very high area of concern.

The CHAIRMAN. All right.

Senator HEINZ. Mr. Chairman, will you yield for a question—a brief discussion between ourselves?

The CHAIRMAN. Yes, sure.

Senator HEINZ. I agree that it was very good to put the date off to February 1. But I am troubled as to whether or not the Secretary, the way the law was written by Congress, has the authority to spend the money. I fear that Congress put him in a straight jacket from which he may not be able to financially escape.

The CHAIRMAN. Well, I have asked him to address the same kinds of concerns that you have expressed, and I anticipate some immediate reaction to that.

Ms. Wilensky, thank you very much for your testimony.

Dr. WILENSKY. Thank you, Mr. Chairman.

The CHAIRMAN. I might say, Senator, I am advised by staff that we believe the Secretary has the authority under the exceptions process, but that he may have some reluctance to exercise it because of setting a precedence. I think we have a job to try to accelerate that.

I would like to now call Mr. Gerry. Mr. Gerry, we are pleased to have you before the committee to discuss your nomination to this important position for the Department of Health and Human Services. As the Assistant Secretary for Planning and Evaluation, you are going to be a key participant in developing and evaluating policies for income, security and health programs over which this committee has jurisdiction.

I know that you are well respected for your work with the disabled and I expect that your strong background and interest in issues relating to the developmentally disabled will be extremely helpful to the members of this committee because we will be having some legislation on that particular issue this year. I look forward to your testimony.

I defer to Senator Packwood for any comments.

Senator PACKWOOD. No questions, Mr. Chairman. I will be right back.

The CHAIRMAN. Are there any comments?

[No response.]

The CHAIRMAN. If not, Mr. Gerry, would you proceed.

STATEMENT OF MARTIN H. GERRY, TO BE AN ASSISTANT SECRETARY OF HEALTH AND HUMAN SERVICES

Mr. GERRY. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, it is an honor and a privilege to appear before this morning as President Bush's nominee for the position of Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services. That honor is of even greater significance to me because, if confirmed by the Senate I will have the opportunity to serve under Secretary Louis Sullivan, a man for whom I have the highest respect and admiration.

Mr. Chairman, I would like to summarize the major responsibilities of the position for which I have been nominated by the President and then briefly address my experience and qualifications. My written statement, Mr. Chairman, proceeds to lay out five basic characteristics of the job and then to discuss what has been now, I guess, a 21-year career in Washington.

Because I know of the committee's pressing schedule today I would like to leave out the detailed discussion of these points in my oral presentation—I believe my statement has been provided to members of the committee—and would like to simply say, Mr. Chairman, before concluding my remarks that I would like to express my sincere thanks to you and to other members of the committee and to the staff of the committee for the courtesy and consideration which you have shown me throughout the confirmation process.

I would be happy to answer any questions which you or other members of the committee may have concerning my candidacy.

The CHAIRMAN. Well, one of the things I want to talk to you about is the JOBS program. We enacted that in the 1988 welfare reform legislation and you had quite a bit of bipartisan support on this committee. But the key word in that is trying to have it "effective." We will be depending on you to tell us along the way each step of it, is it being effective, is it actually working.

Do you think you can make it under your leadership a priority for the Department? And if so, do you think you are going to have the resources to do the job?

Mr. GERRY. Well first, Mr. Chairman, let me say that I share your concern about the importance of the program and I have for many years been concerned about precisely the population of individuals covered by the program and the strategies which the Congress, I think very properly saw fit to put into law through the act.

There is, of course, already a significant concern in the Department about the program. I know that the Under Secretary and the Secretary both have been paying close attention to the program's progress. Let me say that I do intend to—and I hope I will be able to—have a significant impact on the discussions of that program.

I think I may be particularly qualified to do that because in addition to experience in the health and human services area, I have had a lot of experience with education programs. For 3 years I have been a special master for the District of Columbia Superior Court in a case involving the juvenile justice system for the District of Columbia and have had an opportunity in that role to spend a lot of time looking at the education, vocational training of individuals who have left school and are in the custody of the District of Columbia. Many of these young men are the fathers of some of the children of the young women in the JOBS program.

I have had a chance to really look in some depth at the kinds of programs and services that would work best for people who, to a large extent, have not enjoyed—and that is probably an understatement, Mr. Chairman—their school of experience, but do want education and training to pursue and to obtain gainful employment.

I think it is important that the States be supported in being creative in integrating those educational programs and not be pushed into traditional approaches against their better judgment when those approaches have not necessarily worked very well for this population of young people.

I am very interested in outcomes and in long-term gainful employment. I am equally concerned also, Mr. Chairman, with the other aspects of the program. Certainly the child care aspects of the program are very important. And having worked with many

States, I have some concerns about the lack of communication within the States between the State welfare agencies, which are responsible for the overall implementation of the program, and the State education agencies—the Head Start providers and others—who will have and should have an important part of the child care aspects of the program.

So I hope that we can effectively coordinate the program. I certainly can pledge to you my interest in it. I believe, having looked at our resources, that we can effectively evaluate it. But we are going to need the help of a lot of State and local agencies if we are going to do that job really effectively.

The CHAIRMAN. Well I look at the developmentally disabled and think of community-based services and home services. I have a deep interest in that and would like very much to have your counsel and advice as we go along the way as to what is working and was is not working, and what you think we ought to be doing about it, and having adequate resources to pursue it.

I defer to Senator Rockefeller for any comments.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I just have one question which is generic. I understand you will be involved with the HHS Task Force on the uninsured and long-term care.

Mr. GERRY. Yes.

Senator ROCKEFELLER. One of the problems that Dr. Wilensky actually answered in the affirmative is that it is a tremendous task to confront the huge health care problems we have in this country; 31 million Americans are uninsured, another 10 to 20 million Americans are underinsured. Not to speak of those who need long-term care protection; 40 percent of those individuals who need long-term coverage are under 65, and many of them are children.

The President has made it fairly clear that he does not want to raise taxes during this term. That can have two effects on an Agency within the Administration. One, it can encourage you to talk very heavily about medical malpractice which is certainly a major factor—defensive medicine drives up the cost of medicine—and some of the things I mentioned earlier to contain costs—outcomes research, practice guidelines, and utilization review. In other words, that takes you so far in terms of holding down costs. And if you hold down costs, then presumably you can provide more care.

But at some point—at some point—when you are bringing people into the system who are not there now, it costs money. My generic statement/question to you is the following. I hope that you will not be afraid in your own participation on the HHS task force, that you will not be afraid of the need for additional resources.

Because if you are, it may be a deficient report. Now that is not to say that just spending money solves problems. But I think in the case of the uninsured and long-term care, it is virtually impossible to come up with a solution that does not require additional resources.

Mr. GERRY. Let me see if I can try to respond to some of your concerns, Senator Rockefeller.

First let me say I served on the Disability Advisory Council—not the current one but its predecessor—which recommended to Congress a raise in the level of substantial, gainful activity for the SII

and SSDI programs from $300 to $490. Ultimately the President approved $500.

Some argued on our Council that and SGA increase was somehow going to be an increase in expenditure. In fact, we heard this argument from various actuaries and you can get actuaries to say almost anything you want them to say if you tell them in advance what it is you want them to come out with.

I voted and supported very strongly a substantial raise in the level of substantial, gainful activity because I believe that we have to look at the total economic impact of the proposal we are considering.

I have spent the last year at Stanford looking at the economic costs of what I call program failure. That is to say it is not necessarily cheap to do things poorly. It is not necessarily going to save money for taxpayers, for example, to have uninsured people. Because, in fact, for the most part those people do ultimately receive some type of care. It is usually not the best kind of care; it is usually at the wrong time. But it is often very expensive.

In fact, the experience that I have had for the last couple of years looking at Medicaid eligible children in California confirms the same conclusion. These children who, in fact, do not have real access to services often come into the service system through the emergency rooms at a point in time when their needs are acute, but where costs can multiply and escalate tremendously.

I am not trying to evade your point which is, could we reach the point where we would have to say even if we properly analyzed the system we would have to spend more money. My experience is that we are spending a great deal of money to do a very poor job. It is just that the money is spent at different times. Some of those children, for example, who do not receive appropriate health care also may end up 15 years later in long-term dependency systems, which may cost the taxpayers of this country a great deal of money because we have foolishly failed to provide services at the proper point in time.

I hope one thing I can bring to the Department is a little bit more of a holistic sense about what things cost. I am not, for example, convinced that to not spend money on health saves money. I think it costs money. I think that we have to look at the total economic picture.

This committee, for example, certainly sees quite regularly, the long-term costs that result from decisions that are made at earlier points in time, and often in programs that are under the jurisdictions of other committees. I think the executive branch has some of this same problem because it tends to be organized into reasonably tight little boxes in which some of us look at the outcome costs and others are looking at what we are spending up front.

Luckily, our Department has a good deal to do on both sides of the issue. We have a Head Start program to run. We have child care and child neglect programs to run. I think we have to balance the costs. It may be that we should be spending considerably more for proper health care for the uninsured people you are describing. Whether that will cost us more in the long run I do not know. I am not assuming that in every event it will. But if it does, then we

have to as a country, honor our basic social commitment to provide access to quality health care for every citizen.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Packwood?

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman, just one question.

Now that I can look at you from both the Labor and Finance Committees I see that it is an enormous responsibility which you have. Can I ask you the resource question? It seems to me that it is so often the case that when we are trying to hold down costs we hold them down in the areas in which somebody might be able to tell us how to do something better.

Applying that analogy to your Department, what is your current view of the adequacy of the financial and other resource commitment that has been made to ASPE and the support systems that the Secretary needs in policy and planning?

Mr. GERRY. Well I have certainly looked at that fairly carefully, as you can imagine, Senator Durenberger; and I have noticed that there has been a decline in both the budget and the staff.

It is difficult for me, however, to access the effectiveness until I have an opportunity to really work directly with the Secretary. Because a good deal of the fluctuation in the ASPE budget has had to do with certain special assignments that have been from time to time given to the office by different Secretaries for different issues.

I would like to see us—and I think for a variety of reasons for me I find it very comfortable—work more effectively with the other Agencies in the Department. Specifically Gail Wilensky and I know each other well. I have know Gwen King for many years. And I feel that we need to build a much more cooperative, rather than semi-competitive, relationship between the agencies.

In other words, I think that my job should really be to help the Secretary get the total view that no particular Agency or staff division can provide, but not to duplicate the work that other Agencies and staff divisions can do and do do.

In talking with Dr. Sullivan at length about this, I think that what he wants most is the total picture, which I think every Secretary—having worked for Secretary Richardson, Secretary Weinberger wants. I think that that gives ASPE a differentiated function.

Secondly, we have had a relationship over time with the Inspector General's Office of the Department on program evaluation. I have spent some time with the Inspector General. I think we can improve the integration of those roles. I think that sometimes some of the information that the Inspector General may develop does not get to the Secretary as efficiently and effectively as it should; and sometimes it is not really integrated with the information from the program agencies.

So I think I would be in a better position to answer your question after we have tried to do things more or less along those lines. I do not know that there is any magic answer in terms of budget or staff.

The CHAIRMAN. Thank you very much, Mr. Gerry.

Mr. GERRY. Thank you, Mr. Chairman.

[The prepared statement of Mr. Gerry appears in the appendix.]

The CHAIRMAN. Our next nominee will be Mr. Abraham Shashy, Jr., who has been nominated to be the Chief Counsel of the Internal Revenue Service. The Chief Counsel is the top attorney in the IRS.

Mr. Shashy, I am delighted to have you before us. You are no stranger to tax law. I am particularly impressed with your background in the private sector where you have practiced law for 14 years. But you have also been acclaimed for teaching tax law.

Frankly, from what I have seen and heard, I think you are imminently qualified for the challenges that you will face at the IRS. I think we are fortunate to have someone of your credentials who is willing to take the job.

With that, I would defer to the ranking member.

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. No questions, Mr. Chairman.

The CHAIRMAN. Why don't you proceed with your opening statement?

STATEMENT OF ABRAHAM N.M. SHASHY, JR., TO BE AN ASSISTANT GENERAL COUNSEL IN THE DEPARTMENT OF THE TREASURY

Mr. SHASHY. Thank you, Mr. Chairman, for the kind words. I know you are busy so my remarks will be brief. I would like to thank you, Mr. Chairman and the committee, for scheduling this hearing so promptly after reconvening and for the kind words this morning. I am honored to have been nominated for the position and I am eager to serve. I would also like to thank Senator Gramm for taking the time to introduce me this morning.

If I am confirmed as Chief Counsel I will do my best to ensure that the Office of Chief Counsel continues to provide high quality independent legal services to the Commissioner, and in doing so achieves its missions, which in my mind are three fold.

First, to fairly and promptly interpret and implement the tax laws in the simplest, most administrable manner. Second, to resolve tax controversies on a satisfactory basis without litigation, if possible. And third, where that is not possible, to advocate the Government's position vigorously in litigation.

I would be pleased to answer any questions the committee might have.

The CHAIRMAN. We have been reading about a budgetary crisis in the IRS, the problem of retaining qualified and experienced personnel and the lack of updated computer services and management practices.

Do you think we are committing enough assets to the IRS to maintain credibility in our tax system, considering that the audit rate has dropped substantially. Our voluntary tax system relies on self-enforcement and self-reporting. Are we in danger of having a substantial increase in the number of taxpayers who think the

odds are very much in their favor that the IRS will not check to make sure they comply with the law?

Mr. SHASHY. I think the budgetary issues of the IRS and the Office of Chief Counsel are in fact real issues. The IRS has extremely good personnel at a number of levels. Those people are very productive and they get an awful lot done.

At the same time, there is an indisputable gap that has developed and is growing between public sector and private sector compensation. There is always a need for more good people and it is difficult to hire them and it is difficult to retain them in the face of a gap like that. You can attract people by appealing to their sense of public duty; you can attract people by offering them work experience that they might not get in the private sector—responsibility a little earlier, and a great learning experience; you can attract people by offering them an environment where the pressures are different and probably less than in the private sector; but ultimately when it comes time to pay the rent, pay the bills, put a little money aside, the temptations of the private sector I think are great.

So it would obviously help if the Service and the Office of Chief Counsel had additional resources to be able to hire and retain good people and also to continue the process of systems modernization.

With respect to the impression among the taxpaying public that perhaps the enforcement will not reach them, I think that is always a concern to the Service and it is a concern that is addressed in a number of ways. It is addressed by the Service trying to pick and choose whose returns are audited in a fashion that sends a message to the public that every segment of the public—high paying taxpayers, low paying taxpayers, wealthy people and people who aren't so wealthy—in fact will be scrutinized by the Service.

So it is an ongoing process that can be addressed in a number of ways. But it is a continual concern, I believe.

The CHAIRMAN. I read that there are approximately $60 billion in delinquent IRS accounts. Do you have any feel for what percentage of that is collectible?

Mr. SHASHY. Mr. Chairman, I do not. I am not that familiar with the detail of the facts. I do not know what percentage is collectible.

The CHAIRMAN. Mr. Shashy, we had one of our toughest jobs ever last year meeting the budget targets and reducing the deficit. I think we are going to have a tougher time this year. If you could tell us how to accelerate the collection of the delinquent accounts, it would sure help.

Mr. SHASHY. Well I am certain that there will be an effort to accelerate the collection of those delinquent accounts, that there will be an attempt to determine which of them are good and which of them are bad, and to enforce collection. I know that the Office of Chief Counsel, which in fact provides collection litigation services to the Commissioner, is certainly going to do what it can and whatever is required of it to see that those collections are made as quickly as possible.

In addition to that, I know that the Office of Chief Counsel will also focus on a significant amount of potential tax revenue that is lodged in controversy matters—so called large case inventory,

which has aged, which is aging, and probably more so than everyone would like. It will be focused on and there will be an effort to accelerate the resolution of those controversies also.

The CHAIRMAN. I defer to Senator Packwood.

Senator PACKWOOD. You have a good background teaching tax law in addition to practicing. In the Tax Reform Bill, as just a generalization, we eliminated lots of deductions and exemptions, and lowered rates. Would that be a reasonably accurate statement of what we did?

Mr. SHASHY. Yes, sir.

Senator PACKWOOD. Is that philosophically a direction we should continue in, in your judgment?

Mr. SHASHY. I believe it is. I think philosophically it is the direction the tax law should go. I think it is always difficult to balance that against the appeal of using the Tax Code to encourage certain types of economic and social behavior by building in preferences of different types. But I think certainly at the time the Tax Reform Act was passed, it was movement in the right direction. I think one question a lot of people had, and perhaps still have, is whether that was a temporary movement or whether it is movement that in fact will be protected and will sustain.

Senator PACKWOOD. But if we could, we should push it further, get rid of further deductions and exemptions and again lower the rates? Assuming we reach a trade off so that we are not losing money.

Mr. SHASHY. If you can do that, yes.

Senator PACKWOOD. Okay.

Mr. SHASHY. Up to a point I think there are probably some things you could do to broaden the base a bit, although I believe they are becoming fewer and farther between.

Senator PACKWOOD. Well, not really. You have some immense ones like property tax, mortgage interest, and State income tax deductions. Immense quantities of money are involved.

Mr. SHASHY. That is true.

Senator PACKWOOD. What do you think about the taxation of fringe benefits?

Mr. SHASHY. The taxation of fringe benefits, I believe, it is a tough issue often times because of difficulties in administering the taxation of certain types of fringe benefits.

Senator PACKWOOD. You mean the valuing of them?

Mr. SHASHY. The valuing of them, keeping up with them, reporting requirements. There are an awful lot of fringe benefits of lesser value that a lot of people on a widespread basis enjoy and it is difficult to keep up with it. I am not sure that the cost of administration would be worth the revenue collected.

But as a philosophical matter, I do not see any reason why fringe benefits should not, in fact, be taxed.

Senator PACKWOOD. Thank you.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. I have no questions, Mr. Chairman. But I did go over Mr. Shashy's resume last night and it is a very distinguished one. I look forward to supporting his nomination.

Mr. SHASHY. Thank you, Senator.

The CHAIRMAN. Mr. Shashy, thank you very much for your appearance and good luck to you.

Mr. SHASHY. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Peter Nunez, if you would come forward, please.

Mr. Nunez has been nominated for the post of Assistant Secretary of the Treasury Department for Enforcement. That position is responsible for the formulation and coordination of the Treasury Department's law enforcement activities. That includes oversight and supervision of the Bureau of Alcohol, Tobacco and Firearms, the U.S. Customs Service, the Secret Service, and the Federal Law Enforcement Training Center.

As Senator Wilson stated earlier, you have been the Federal Prosecutor in San Diego for 16 years. That gives you first-hand exposure to many of the law enforcement issues you will face at Treasury, particularly with United States-Mexican border concerns.

We expect some innovative strategies from you for combatting illegal narcotics, firearms traffic and excise tax evasion schemes. With the Customs Service, you have to remember that you are wearing two hats—one as enforcer of the laws and the other as facilitator of legitimate trade over our borders. That requires a great deal of sensitivity.

Mr. Nunez, we are pleased to have you. I defer to my colleague, Senator Packwood.

Senator PACKWOOD. I have some questions, but I have no statement, Mr. Chairman.

The CHAIRMAN. Senator Heinz, any statement?

Senator HEINZ. Yes. Mr. Chairman, I have a very brief submission on behalf of Senator Thurmond, if I might.

The CHAIRMAN. Fine. Thank you.

Senator HEINZ. Mr. Nunez, Senator Thurmond is quite interested in receiving answers to eight questions. In order to save the time of the committee, I will ask that they appear in the record at this point as if propounded to you in full. We will provide you this list of questions.

It would be much appreciated by Senator Thurmond and myself if you would respond to his questions as clearly and completely as you can at the earliest possible time.

Mr. NUNEZ. Certainly, Senator.

Senator HEINZ. Thank you, Mr. Chairman.

[The questions appear in the appendix.]

The CHAIRMAN. Mr. Nunez, you face competing objectives at Customs. One is to expedite commercial traffic across borders. The competing goal is to stop evasion of the laws and smuggling.

One of the problems we have had in the past is developing good communications with the business community along the border. How would you balance these competing roles?

STATEMENT OF PETER K. NUNEZ, TO BE AN ASSISTANT SECRETARY OF THE TREASURY

Mr. NUNEZ. Mr. Chairman, I am familiar with those issues, at least in some respects, from the time I was a Prosecutor in San

Diego. It was not uncommon for people in the community to seek me out as well as anyone else they could find to discuss those very issues. So I have been aware of them for some period of time.

It is a difficult balancing act. We have a tremendous drug problem. We have a tremendous immigration problem. And how to balance that with fair and quick inspections and processing of goods is, I know, something that is high on Commissioner Hallett's agenda and the Treasury Department's agenda. There are outreach programs that have been set up as I understand it to deal with the trade community to make sure that their views are being taken into consideration.

The CHAIRMAN. A really interesting thing has happened. We have seen a substantial decrease in the number of aircraft seizures by the Customs Aviation Branch operating out of Houston since 1986. How do you account for that downturn?

We had an air strip on our family ranch that the Customs Service kept under surveillance because of the possibility of planes coming in at night from Mexico and landing there without our knowledge. I do not think they ever apprehended one, although we turned in two or three private planes to them thinking that they might be suspect.

Senator PACKWOOD. They would land them and just leave the planes there?

The CHAIRMAN. Oh, sure.

Senator PACKWOOD. Is that right?

The CHAIRMAN. They would get rid of the dope and take off again. So Customs kept it under surveillance, as they did with all the major strips on ranches in that area.

But there has been a substantial decrease in the number of airplane seizures. Can you tell me why?

Mr. NUNEZ. Not specifically. I know that the theory of increased enforcement along the Southwest border is to act as a deterrent and I know that Customs over the last 5 years has made a tremendous—had a tremendous increase in their effort to interdict air smugglers. If we are lucky, perhaps that is having some deterrent effect.

The CHAIRMAN. I am hopeful that, when the President announces his drug program today, he will designate the Southwest border—Mexico/Texas—as a drug intensification area or assign additional personnel to that area. I would hope that you could help commit the necessary resources to implement this policy, so that it does not become just something in name only. You have some understanding of what we have been putting up with along that border.

Mr. NUNEZ. I am well aware of the circumstances, at least along part of the Southwest border where I have been, and I share the Chairman's concern. I think you will be pleased with what you see in the new strategy.

The CHAIRMAN. I have seen one of those areas that, in spite of a long drought and low crop prices, had some new houses and some new pickup trucks. I have my own opinion of where that money came from. So I would urge an intensification of effort there.

Do you have any further questions?

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Senator PACKWOOD. Mr. Nunez, when you were a U.S. Attorney or when you were Chief Assistant, did you ever have any complaints from your women lawyers or staff members about being treated unfairly?

Mr. NUNEZ. When I was the U.S. Attorney we had an office reorganization—I believe it was in 1986—in which we picked a number of team leaders, a new structure that we adopted in the office and there were some of the women in the office who felt that they should receive a quota arrangement of——

Senator PACKWOOD. That they should receive a quota?

Mr. NUNEZ. Right, a mathematical computation. There were so many women in the office and therefore so many of the team leaders should have been selected from those.

Senator PACKWOOD. As far as you are concerned, their argument was it should be on a quota system, they were not arguing merit?

Mr. NUNEZ. That is my impression. And, in fact, I am very proud of the fact that the first woman supervisor ever appointed in San Diego was appointed by me and, in fact, my Chief Assistant, subsequent to that, was a woman also.

Senator PACKWOOD. And you had no other complaints from any of your women professionals about management of the office?

Mr. NUNEZ. Not that I am aware of.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Nunez, I have had some of the same information provided to me. I am going to defer reporting you out this morning. I would like to visit with you about it and talk to you about some of those concerns; perhaps Senator Packwood would join us.

I have no further questions. Thank you very much.

Mr. NUNEZ. Thank you.

[Whereupon, the hearing recessed at 10:43 a.m.]

APPENDIX

Alphabetical Listing and Material Submitted

Prepared Statement of Martin H. Gerry

Mr. Chairman and members of the Senate Finance Committee, it is an honor and a privilege to appear before you this morning as President Bush's nominee for the position of Assistant Secretary for Planning and Evaluation of the United States Department of Health and Human Services. That honor is of even greater significance to me because, if confirmed by the Senate, I will have the opportunity to serve under Secretary Louis Sullivan, a man for whom I have the highest respect and admiration.

Mr. Chairman, I would like to summarize the major responsibilities of the position for which I have been nominated by the President and then briefly address my experience and qualifications. The position of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services carries with it five major responsibilities:

(1) Monitor the evolution of policy within the Executive and Legislative Branches;

(2) Assist the Secretary in developing policy, related legislative proposals and the department's budget;

(3) Oversee the department's economic and policy analysis, and ensure that policies and regulations are consistent department-wide;

(4) Evaluate existing department programs, and assist the Secretary in monitoring policy and program implementation; and

(5) When required, act as spokesperson for the department on policy matters.

Mr. Chairman, I believe that my training, experience and personal attributes ensure that I will be able to carry out successfully each of these responsibilities.

During over 20 years in Washington, I have had extensive experience in monitoring the evolution of policy within all three branches of the Federal government. For 7 years, as Assistant Director (Policy and Program Development), Deputy Director and Director of HEW's Office for Civil Rights, I worked closely with staff of the Office of Management and Budget and the White House Domestic Council in virtually all aspects of the Executive Branch policymaking and budget processes, and monitored all legislative activity in both Houses of Congress related to civil rights and equal opportunity matters.

In 1977, as a Consultant to the President's Reorganization Project, I gained additional experience with Executive Branch policymaking and budget matters within the Office of Management and Budget, and my eleven-year tenure as Counsel to the House Wednesday Group provided in-depth experience with regard to the formulation and evolution of policy within the Legislative Branch, including the development of legislation directly relating to child care, child abuse, welfare, medical insurance and social insurance.

Since 1977, I have also worked with a large number of Federal, state and local government agencies with respect to the development and implementation of policy in several health and human service areas. This experience has included not only policy research and analysis, but substantial involvement in the actual planning, provision and financing of health, mental health, habilitation/rehabilitation, and social services (including child care) for "at-risk" infants, children and adolescents, disabled and incarcerated adults, and to low-income and elderly persons.

As a member of several Executive Branch task forces and commissions, as Counsel to the House Wednesday Group and as a Visiting Scholar at the University of

Maryland and last year at Stanford University, I have carried out numerous legal, economic and policy analysis activities at the national level in a variety of social policy areas. As a result of these activities and because of my substantial experience with policy development and implementation at the State and local level, I have gained a practical command of the laws and regulations governing the determination of eligibility for most health, social welfare and social insurance benefits, and a working knowledge of the day-to-day administration (including the operation of related "due process" and "hearing and appeal" systems) of most of these programs.

Throughout my 20 year career in Washington, I have continued to be actively involved in the development, implementation and enforcement of numerous laws and regulations designed to ensure non-discrimination in the provision of health, mental health, and social services and of assistance payments. I have written and lectured extensively, and testified before Congress on a wide variety of social policy issues.

Mr. Chairman, before concluding I would like to express my sincere thanks to you, other members of the Committee and to the staff of the Committee for the courtesy and consideration which you have shown me throughout the confirmation process. I would be happy to answer any questions which you or other members of the Committee may have concerning my candidacy.

Attachment.

BIOGRAPHY

MARTIN H. GERRY

EDUCATION

Stanford University, B.A. 1964; Stanford University, J.D. 1967

PROFESSIONAL EXPERIENCE

1989-1990 — Visiting Scholar, Stanford University, Stanford, California

This position will involve extensive policy research on a range of civil rights, educational, economic and social policy questions, including the social and economic consequences of educational and employment failure for "at risk" youth, and the evolution of a new Federal social policy construct.

1978-present — President, Fund For Equal Access To Society

This position involves the management of a small non-profit organization which has received grants and contracts from the Federal government and State agencies to conduct policy research, draft integrated services and education financing plans, regulations, policies and guidelines for Federal, state and local agencies, and to prepare reports for Federal and state agencies.

1977-present — Special Counsel, Wednesday Group of the U.S. House of Representatives

This part-time position requires legal and policy research and the analysis and preparation of proposed legislation for approximately 35 Republican members of the U.S. House of Representatives.

1975-1977 — Director, Office For Civil Rights, U.S. Department of Health, Education and Welfare

This was the largest of the Federal government's civil rights enforcement agencies. The Director reported directly to the Secretary and supervised over 1,100 investigators, negotiators and attorneys with multiple program responsibilities. The Director was also responsible for the development of a wide range of Federal civil rights regulations and policies prohibiting discrimination on the basis of race, national origin, sex, handicap and age.

1973-1975 — Assistant to Secretary Caspar Weinberger, U.S. Department of Health, Education and Welfare

19[illegible]-1973 — Assistant to Secretary Elliot Richardson, U.S. Department of Health, Education and Welfare

These positions involved a wide variety of policy research and development activities, including development (as General Counsel of the HEW Task Force) of comprehensive regulations implementing

Title I of the Elementary and Secondary Education Act of 1965, HEW regulations governing human experimentation by health research facilities, and civil rights policies and enforcement programs governing the provision of appropriate education services to children who are non-English speaking.

1969-1970 — Executive Assistant to Director, Office for Civil Rights, U.S. Department of Health, Education and Welfare

1967-1969 — Associate Attorney, Mudge Rose Guthrie & Alexander, New York City

POLITICAL ACTIVITIES

1988 — Adviser (Civil Rights & Education), Domestic Policy Staff, Bush-Quayle 88

Executive Advisory Committee, Disability Coalition, Bush-Quayle 88

1984 — Vice-Chair, Disability Committee, Reagan-Bush Campaign

1980 — Research Staff, Reagan-Bush Campaign.

1978-1980 — Advisory Committee on Human Concerns, Republican National Committee

SELECTED PROFESSIONAL ACTIVITIES

Current:

- Senior Consultant, Center for Educational Research and Innovation, Organization for Economic Cooperation and Development (Paris)
- Education Monitor, District of Columbia Juvenile Correctional System
- Vice Chair, National Legal Center for the Medically Dependent and Disabled (Indianapolis)
- Pro Bono Counsel: Association For Retarded Citizens, U.S.; Spina Bifida Association of America; National Down Syndrome Congress; The Association For Persons With Severe Handicaps

Past:

- Visiting Senior Research Scholar, University of Maryland (College Park) (1988)
- Member, Disability Advisory Council, U.S. Department of Health and Human Services
- Faculty member, Training Program for Federal Judges, Danforth Foundation and the Judicial Conference of the United States
- Member, Project Advisory Board of the Legal Procedures for Handicapped Infant's, American Bar Association (1985)

- Member, Advisory Panel on Student Discipline, American Bar Association (1980-81)

- Co-Chair, Congressional Commission on the Financing of Free and Appropriate Education for Special Needs Children (1982-83)

PROFESSIONAL MEMBERSHIPS

- Bar, State of New York (1967); District of Columbia (1977); United States District Court for the District of Columbia (1979); United States Supreme Court (1985)

- The Center For Excellence in Government

PERSONAL INFORMATION

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PREPARED STATEMENT OF PETER K. NUNEZ

Thank you, Mr. Chairman, for the expeditious scheduling of this hearing. I also want to express my appreciation to President Bush for nominating me to be the next Assistant Secretary of the Treasury for Enforcement, as well as Secretary Brady for recommending me to the President for this important position. I will do my best to fulfill their confidence in me should my nomination be approved by the Senate.

I look forward to the challenges presented by this appointment to help lead the Treasury Department's enforcement efforts during this period of urgency in dealing with our nation's crime epidemic. During sixteen years of prior service to the Federal Government as a prosecutor in San Diego, California, I have worked side-by-side with every Federal law enforcement agency in trying to stem the tide of lawless behavior. In particular, I have first-hand experience in dealing with the agencies primarily involved in trying to maintain law and order along the Southwest Border. The efforts to reduce drug smuggling, illegal immigration, violence, money laundering, and a number of other crimes endemic to the border have occupied my professional life since 1972. I have worked closely with the Customs Service, the Secret Service, the Bureau of Alcohol, Tobacco, and Firearms, and the Internal Revenue Service's Criminal Intelligence Division to ensure that their efforts were successful. My relationship with the Border Patrol and INS, with the Drug Enforcement Administration, with the FBI—in short, with all other Federal, state, and local agencies in Southern California—has been equally close and supportive. I remain committed to a unified, cooperative, law enforcement effort based on the concepts of teamwork and efficiency. I hope that my experience as a Federal prosecutor and my philosophy of unqualified cooperation can be of value in improving the efforts we must continue to make in the area of criminal law enforcement.

I would like to take a moment to thank and acknowledge several people who have helped me arrive at this place in time. Salvatore R. Martoche, the man whose shoes I will try to fill, has been a friend since we served together as U.S. Attorneys beginning in 1982. His counsel and advice have been invaluable to me over the years, and if confirmed, I look forward to working with him for a smooth transition.

I also pay tribute to the man who gave me my first opportunity to serve the public interest after graduating from law school. My thanks to the Honorable Gordon Thompson, Jr., now the Chief Judge for the Southern District of California, for his faith, support, and inspiration.

Finally, to my family—my parents for supporting me with their love and attention, and to my wife and sons, who have sacrificed much so that I could pursue my desire to serve the public interest.

Thank you very much. I would be pleased to answer any questions.

A. BIOGRAPHICAL

1. Peter Kent Nunez.

2. 3510 Addison Street, San Diego, CA 92106

3. 08/31/42 - West Reading, Pennsylvania

4. Married - Elizabeth Ann Cohn

5. Jeffrey Nathan Nunez, DOB 10/04/81
Zachary Aaron Nunez, DOB 10/28/86

6. University of San Diego School of Law, 1967-1970, Juris Doctor degree, May 1970

Duke University, Durham, North Carolina, 1960-1964 Bachelor of Arts degree, June, 1964

7. Brobeck, Phleger & Harrison, San Diego, California. Partner, Litigation Department, September 1988 to present

United States Attorney, Southern District of California, San Diego, California, April 7, 1982 through August 31, 1988

Chief Assistant United States Attorney, Southern District of California, San Diego, California, May 31, 1980 to April 7, 1982

Assistant United States Attorney, Southern District of California, San Diego, California, September 1, 1972 to May 31, 1980

Law Clerk to the Honorable Gordon Thompson, Jr., United States District Judge for the Southern District of California, November, 1970 to September 1972

Operations Officer, Pan American World Airways, Los Angeles, California, September, 1966 to August, 1967

Naval Officer, U.S.S. Wexford County (LST 1168), San Diego, California, July, 1964 to July, 1966

8. United States Attorney, Southern District of California, San Diego, California, April 7, 1982 through August 31 1988

Chief Assistant United States Attorney, Southern District of California, San Diego, California, May 31, 1980 to April 7, 1982

Assistant United States Attorney, Southern District of California, San Diego, California, September 1, 1972 to May 31, 1980

Naval Officer, U.S.S. Wexford County (LST 1168), San Diego, California, July, 1964 to July, 1966

San Diego County Drug Abuse Strike Force, 1986 - 1988

Member, San Diego County Alcohol Advisory Board, 1988 - present

Mayor's Committee Against Drug Abuse, 1987 - 1988

9. State Bar of California

United States District Court, Southern District of California

Ninth Circuit Court of Appeal

Supreme Court of the United States

San Diego County Bar Association

Criminal Justice Act Committee, Judicial Conference of the Ninth Circuit Court of Appeal, 1985 to 1988

Board of Directors, The Crime Victims Fund, 1987-1988

Committee on Criminal Discovery and Procedure Before Trial, Judicial Conference of the Ninth Circuit Court of Appeal, 1983 - 1985

Committee to Study and Report on S.1: Conference of Delegates, State Bar of California, 1975-1976

Board of Visitors, University of San Diego School of Law, 1983 - present

Board of Directors, San Diego Volunteer Lawyer Program, 1982 - present

Member, Dean's Search Committee, USD School of Law, June, 1988 - May, 1989

San Diego County Drug Abuse Strike Force, 1986 - 1988

Member, San Diego County Alcohol Advisory Board, 1988 - present

Board of Directors, San Diego Crime Commission, 1988 - present

Mayor's Committee Against Drug Abuse, 1987 - 1988

Board of Directors, San Diego County Council, Boy Scouts of America, 1988 - present

Board of Directors, National Association of Former United States Attorneys, 1989 - present

National Board of Advisors, Federation for American Immigration Reform, 1988 - present

Member, Business Council, Alcohol and Drug Abuse Prevention Task Force, 1988 - present

Citizens' Advisory Committee, San Diego Police Officers' Association, 1989 - present.

10. "Lawyers for Bush", October-November, 1988, State Vice Chair (one of seventeen).

Contributions:

Republican National Committee:

01/84	$100
03/85	$100
12/86	$ 50
12/86	$ 50
09/87	$ 25
09/87	$100
05/88	$100
12/88	$100
04/89	$100
06/89	$ 50
06/89	$ 50

Republican Presidential Task Force

04/89	$120
06/89	$ 50

San Diego County Republicans

04/89	$ 50
07/89	$ 50

California Republican Party

06/89	$ 50

Pete Wilson for Governor

06/89	$100

In addition, between 1979 and 1984, I made miscellaneous contributions totalling less than $1,000, however, I have been unable to locate my records to provide a detailed breakdown.

11. Certificate of Appreciation, California Red Ribbon Campaign, Californians for Drug-Free Youth, Inc., October 25, 1989

Distinguished Community Service Award, San Diego County, October 24, 1989

Community Leadership Award, Lions International, San Diego County, October 24, 1989

Commissioner's Award, U. S. Customs Service, Department of the Treasury - October, 1988

Special Recognition for Drug Enforcement Activities from the Attorney General - February 22, 1988

Distinguished Alumnus - 1984 - University of San Diego School of Law

Awarded Certificate of Appreciation, Drug Enforcement Administration - 1983

Recipient of United States Attorney General's Special Commendation Award - May, 1979

Law Review Scholarship, University of San Diego School of Law, 1969 - 1970

12. Case Note, Perma Life Mufflers, Inc. v. International Parts Corp., 392 U.S. 134 (1968), in 6 San Diego Law Review 117 (1969)

Comment, Fluctuating Shorelines and Tidal Boundaries: An Unresolved Problem, 6 San Diego Law Review 447 (1969)

Book Review, Turner: The Chemical Feast, 8 San Diego Law Review 184 (1971)

Toward a Drug-Free Workplace, USPA Reports, Volume V, No. 1, January/February, 1989

Commentary Re Drugs in the Workplace, Personnel Management Association Source, Spring, 1989

13. ADAPT Business Council Community Seminar, Drug Testing, October 25, 1989

Lions Club of San Diego, October 24, 1989, regarding drug enforcement

Greater San Diego Industry-Education Council, October 18, 1989, regarding local drug problem

Princeton Club of San Diego, October 12, 1989, regarding substance abuse in tne workplace

Federation for American Immigration Reform, October 7, 1989, regarding border enforcement

The Breakfast Club, September 28, 1989, regarding drug enforcement

Vista Republican Women Federated, September 21, 1989, regarding border enforcement

Telesis, September 20, 1989, regarding drugs in the workplace

San Diego Republican Businesswomen, September 14, 1989, regarding crime, drug problems and border issues

Single Volunteers in Politics, September 15, 1989, regarding border issues

San Diego County Federation of Republican Women, September 11, 1989, regarding border issues

California Commission on Drugs, August 3, 1989, regarding private sector involvement in the war on drugs

ADAPT Business Council Community Seminar - Drugs in the Workplace, June 6, 1989

Central Republican Women Federated, June 15, 1989, regarding border issues

Brobeck, Phleger & Harrison Client Retreat, June 16, 1989, regarding drugs in the workplace

Pacific Beach Republican Women, Federated, May 19, 1989, regarding border issues

East County Republican Association, May 17, 1989, regarding border issues

Coronado Republican Women Federated, May 10, 1989, regarding border issues

San Diego Mensa, April 28, 1989 regarding Oliver North trial

Building Industry Association, April 26, 1989, regarding drugs in the workplace

Young Americans for Freedom, San Diego State University, April 25, 1989, regarding border enforcement

California League of Savings Institutions, April 13, 1989, regarding drugs in the workplace

Southern California Bank Security Officers' Association, April 4, 1989, regarding drugs in the workplace

California Senate Select Committee on Border Issues, Drug Trafficking, March 22, 1989, regarding border enforcement

San Diego County Bar Association, Corporate Law Section, March 17, 1989, regarding developments in RICO law

Bachelor's Club of San Diego, March 16, 1989, regarding criminal justice

El Cajon Community Drug Awareness Seminar, February 25, 1989, regarding drug abuse and community involvement

County of San Diego, Community Drug and Alcohol Conference (We've Got the Right), October 21, 1988, regarding reduction of demand for drugs

Brobeck, Phleger & Harrison Client Seminar, October 7, 1988, regarding "Swift Justice: Finding a Fast Track for Business Disputes"

Minority Law Students, November 15, 1986, regarding career opportunities

As the United States Attorney for the Southern District of California from 1982 to 1988, I made numerous speaking appearances for various organizations, but I do not have access to those records any longer.

14. My sixteen years as a federal prosecutor in San Diego has given me the knowledge and experience to deal effectively with virtually any federal law enforcement issue. In particular, due to San Diego's proximity to the Mexican border, I have had an intimate association with the Customs Service, and understand its relationship with other border agencies, such as INS and the Border Patrol, and the Drug Enforcement Administration.

Further, as a U. S. Attorney for six and one-half years, I understand the policy issues affecting law enforcement generally, and federal law enforcement particularly. As a member of various committees of U. S. Attorneys, I have participated in both the formulation and review of national law enforcement policy.

Finally, I think I have earned the respect of law enforcement officials from all federal agencies during my career as a federal prosecutor. I have also worked effectively with state and local agencies, and believe I have the ability to create an attitude of inter-agency cooperation.

RESPONSES OF MR. NUNEZ TO QUESTIONS FROM SENATOR HEINZ

Question 1. The Bureau of Alcohol, Tobacco and Firearms (ATF) is under the purview of the Assistant Secretary, Office of Enforcement, is it not?

Answer. Yes, the Bureau of Alcohol, Tobacco and Firearms (ATF performs its functions and duties under the general direction of the Secretary of the Treasury and under the supervision of the Assistant Secretary, Office of Enforcement.

Question 2. In accordance with Public Law 100-690, ATF is currently formulating final regulations to implement the "Alcoholic Beverage Labeling Act of 1988," which requires that all containers of alcoholic beverages sold or distributed in the United States must have a health warning statement appearing on their labels. ATF has announced that it anticipates publishing final regulations for implementation of the warning label requirement by mid-February. Are you familiar with this matter?

Answer. I am generally familiar with the issues associated with implementation of the Alcoholic Beverage Labeling Act of 1988. I am aware that ATF has recommended a final rule which is currently under consideration by the Department.

Question 3. Would you please share with the members of this committee your view of the role of the Assistant Secretary, Office of Enforcement, in formulating final regulations in compliance with the "Alcoholic Beverage Labeling Act of 1988?"

Answer. In implementing the Alcoholic Beverage Labeling Act of 1988, Congress amended the Federal Alcohol Administration Act (FAA Act). The Secretary of the Treasury has delegated his functions, powers, and duties under the FAA Act to the Director of ATF. The role of the Assistant Secretary, Office of Enforcement, will be to review the recommended decision of ATF in order to determine that it meets the requirements of the Alcoholic Beverage Labeling Act of 1988, as well as the policy objectives of the Administration.

Question 4. Are you aware that it was the intent of Congress that the warning labels be conspicuous, so that they may serve to educate the public?

Answer. Yes, I am aware that the statute requires that the health warnings statement be located in a conspicuous and prominent place on the alcoholic beverage container and recognize that a primary purpose of the Alcoholic Beverage Labeling Act of 1988 is to inform the public of the health hazards that may be associated with the consumption or abuse of alcoholic beverages.

Question 5. Do you believe that it is necessary for the warning labels to be located in a prominent place on containers of alcoholic beverages in order to be effective?

Answer. Yes. I agree that this is an important requirement. The statute clearly requires that the health warning statement appear in a prominent place on the alcoholic beverage container so that consumers are aware of the potential health implications.

Question 6. Do you believe that the warning labels should be easily readable and in a uniform typeface?

Answer. I agree with the language in the statute that requires that the health warning statement appear in a conspicuous and prominent place on the container, as determined by the Secretary, in type of a size to be determined by the Secretary and on a contrasting background.

The regulation should prohibit the use of any typeface that is excessively compressed, or illegible.

Question 7. Do you believe that the abuse of Alcohol is one of the most serious problems facing our country?

Answer. Based upon my experience in San Diego as a Member of the Alcohol and Drug Abuse Prevention Task Force and the San Diego County Alcohol Advisory Board I am well aware that the abuse of alcohol is a serious national problem. I share the concern of citizens, national organizations, industries, state legislatures, the Congress, and the President who have all spoken out forcibly against the toll, in terms of lives lost and talents wasted, that results from alcohol abuse and drunk driving.

Question 8. Finally, are you committed to making Americans, especially pregnant women and our youth, aware of the hazards of alcohol abuse?

Answer. Over the past few years, I have participated in a variety of activities in my community to make sure that all members of the public are aware of the hazards of alcohol abuse. I support the mandate of the Alcoholic Beverage Labeling Act of 1988 to make Americans aware of the hazards associated with alcohol abuse. I believe that the publication and enforcement of regulations implementing the health warning requirement is an important step in this direction.

In addition, I am committed to a course of continued consultation with the Surgeon General as well as with organizations dedicated to informing Americans of the

hazards associated with alcohol abuse. I am also committed to encouraging efforts by the alcohol beverage industry and others to educate the public on this matter.

RESPONSE TO REQUEST FOR INFORMATION

TO: Senate Committee On Finance

FROM: Abraham N. M. Shashy, Jr.

DATE: November 9, 1989

The following information is submitted in response to the Outline of Information Requested of Nominees concerning my possible appointment as an Assistant General Counsel of the Department of the Treasury (Chief Counsel of the Internal Revenue Service). The items listed below are numbered so that they correspond to the numbers of the requests for information in that outline.

If additional information is needed please do not hesitate to contact me at (214) 969-4820.

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A. BIOGRAPHICAL

1.	Name:	Abraham Naif Moses Shashy, Jr.
2.	Address:	4431 Bluffview Boulevard, Dallas, Texas 75209.
3.	Date and Place of Birth:	January 13, 1950; Ocala, Florida.
4.	Marital Status:	I am married to Joy Marie Shashy. (The name "Joy" has been used consistently throughout her life as a shortened version of "Joyce".) Her maiden name was Joyce Marie Taninies.
5.	Children:	Stephen Naif Shashy, 3 years and 9 months old (born January 26, 1986). Laura Noelle Shashy, 2 years and 3 months old (born July 24, 1987).
6.	Education:	08/74 to 08/75: New York University School of Law; LL.M. (Taxation) granted in August, 1975. 09/71 to 12/73: University of Florida College of Law; J.D. granted in December, 1973. 08/66 to 12/70: University of Florida; B.S. (Political Science) granted in December, 1970. 09/63 to 06/66: Ocala High School, Ocala, Florida; High School Diploma granted in June, 1966.

7. Employment Record Since College:

01/71-09/71: Sales clerk and deliveryman at Moses Auto Parts Co., 209 N.E. 1st Avenue, Ocala, Fl. 32670.
03/72-09/74: Part-time research assistant for Professor Richard B. Stephens, 264 Holland Law Center, Gainesville, Fl. 32611.
03/73-09/74: Part-time research assistant for Professor Stephen A. Lind, 264 Holland Law Center, Gainesville, Fl. 32611.
03/73-09/74: Part-time research assistant for Professor James J. Freeland, 264 Holland Law Center, Gainesville, Fl. 32611.
06/73-09/74: Part-time law clerk for James S. Wershow, Attorney at Law, 204 S.E. 1st Avenue, Gainesville, Fl. 32602.
09/73-09/74: Instructor of Legal Writing & Research at University of Florida College of Law, 264 Holland Law Center, Gainesville, Fl. 32611.
09/74-09/75: Part-time Associate with Ayres, Cluster, Curry, Meffert & McCall, P.A., 21 N.E. 1st Avenue, Ocala, Fl. 32670.
06/75-05/76: Part-time law clerk with Upham, Meeker & Weithorn, New York, N.Y. (firm no longer in existence).
09/75-06/76: Instructor in Law at New York University School of Law, 40 Washington Square South, New York, N.Y. 10012.
06/76-06/81: Associate at law firm of Kronish, Lieb, Shainswit, Weiner & Hellman, 1345 Avenue of the Americas, New York, N.Y. 10105.
01/77-06/84: Adjunct Professor of Law at New York University School of Law, 40 Washington Square South, New York, N.Y. 10012.
07/81-05/84: Partner in law firm of Kronish, Lieb, Shainswit, Weiner & Hellman, 1345 Avenue of the Americas, New York, New York 10105.
06/84-present: Partner in law firm of Jones, Day, Reavis & Pogue, 2300 Trammell Crow Center, 2001 Ross Avenue, Dallas, Texas 75201.
01/85-05/86: Part-time Adjunct Professor of Law at Southern Methodist University School of Law, Storey Hall, Dallas, Tx. 75275.

8. Government Experience: None.

9. Memberships:

06/74-04/77: Benevolent and Protective Order of Elks.
09/66-present: Sigma Alpha Epsilon Fraternity.
12/70-present: Phi Kappa Phi Scholastic Fraternity.
01/71-present: Universiy of Florida Alumni Association.
09/71-12/73: Phi Delta Phi Legal Fraternity.
07/74-present: Florida Bar Association.
08/74-present: New York University Alumni Association.
09/74-06/76: McBurney YMCA (New York, N.Y.).
05/77-present: New York Bar Association.
01/86-present: Texas Bar Association.
06/88-present: Park Cities YMCA (Dallas, Texas).
06/89-present: Texas Bar Foundation (Fellow).

10. Political Affiliations and Activities:

Over the past five years I have made political contributions primarily on an indirect basis through my law firm's political action committee. Over the past ten years I have attended various lunches and dinners at which various political figures (including Robert Packwood and Lloyd Bentsen) were the featured speakers. In some instances my attendance was arranged by my law firm and the cost of my attendance, which in the aggregate has not exceeded $500 over the past ten years, was allocated to me by the firm. In those cases, I have no record of any contribution. In one instance in which my attendance was arranged by my firm, a dinner in November, 1988, at which Richard Gephardt was the guest speaker, the cost was borne by me directly in the amount of $250. Specific contributions for which I have records include the following:

(a) Contribution to Republican Presidential Task Force in the amount of $120 on May 23, 1989.
(b) Contribution to Friends of Phil Gramm in the amount of $250 on May 24, 1989.
(c) Contribution to Republican Presidential Task Force in the amount of $60 on July 20, 1989.
(d) Contribution to Republican Presidential Task Force in the amount of $100 on October 8, 1989.

11. Honors and Awards:

(a) Graduated number one, New York University School of Law, LL.M. (Taxation) (1975).
(b) Recipient of Gerald L. Wallace Scholarship, New York University School of Law (1974-75).
(c) Managing Editor, Tax Law Review, New York University School of Law (1974-75).
(d) Editor, University of Florida Law Review.
(e) Graduated with Highest Honors, College of Law (1973).
(f) Order of the Coif, University of Florida College of Law.
(g) Graduated with High Honors, University of Florida, December 1970.
(h) Phi Kappa Phi Scholastic Fraternity, University of Florida.
(i) National Honor Society Member.

12. Published Writings:

I have not written any books or reports. I have written two technical articles addressing subject matter in the tax law. The titles of the articles, and dates and places of publication, are as follows:

(a) "Properties of Property: Indigestion from Corn Products", co-authored with Joel Rabinovitz, Esq., published in University of Florida Law Review in 1975.

(b) "The Long and the Short of Straddles as a Tax Saving Device: New Law", published in the New York University Fortieth Annual Institute on Federal Taxation in 1982.

13. Speeches:

I have lectured frequently at seminars and workshops during the past three years. In every instance, the subject matter was an aspect or area of the tax law. In some instances, I prepared outlines and/or other materials that were distributed to students and/or seminar registrants (two copies enclosed). The lectures during the past three years were as follows:

(a) 10/21/86: "Limitations on Losses and Credits from Passive Activities" - 1986 National Institute on Real Estate Taxation.

(b) 11/22/86: "Recapitalizations, Restructurings and Other Corporate Readjustments" - The Tax Reform Act of 1986; Corporate Tax Planning Workshop (New York University School of Law).

(c) 06/22/87: "Financial Instruments -- Mortgage Backed Securities" - The Graduate Tax Workshop XVIII (New York University School of Law).

(d) 10/29/87: "Tax Reform and Strategic Planning For Real Estate in 1987" - 1987 National Institute on Real Estate Taxation.

(e) 11/14/87: "Recapitalizations, Restructurings and Other Corporate Readjustments" - Corporate Tax Planning After the Tax Reform Act of 1986 Workshop (New York University School of Law).

(f) 01/12/88: "Tax Reform and Strategic Planning For Real Estate in 1987" - 1987 National Institute on Real Estate Taxation (repeat of #d above).

(g) 06/13/88: "Real Property Transactions" - Graduate Tax Workshop XIX (New York University School of Law).

(h) 11/11/88: "Asset Disposition Techniques After General Utilities Repeal" - Corporate Tax Planning For Today. (New York University School of Law).

(i) 01/24/89: "Post General Utilities Techniques for Corporate Asset Dispositions Including Dispositions of Subsidiary Stock" - Tax Executives Institute, Dallas Chapter.

(j) 05/19/89: "Post General Utilities Techniques for Corporate Asset Dispositions Including Dispositions of Subsidiary Stock" - Second Annual Advanced Institute for Corporate Tax Planning - Corporate Tax Committee, State Bar of Texas.

(k) 06/02/89: "Limitation on Losses from Passive Activities" - 41st Annual Virginia Conference on Federal Taxation (University of Virginia).

(l) 06/06/89: "Post General Utilities Techniques for Corporate Asset Dispositions Including Dispositions of Subsidiary Stock" - Graduate Tax Workshop XX (New York University School of Law).

(m) 10-13-89: "Post General Utilities Techniques for Corporate Asset Dispositions Including Dispositions of Subsidiary Stock" - Corporate Tax Workshop -- Planning In Today's Tax Climate. (New York University School of Law).

14. Qualifications:

My qualifications for the position include the following:
(a) Outstanding performance in education endeavors.
(b) Strong interest in the ongoing development of the tax law as evidenced by
(i) successful broad-based tax law practice for over 14 years (over eight years as a partner);
(ii) one year of teaching tax law full-time at a nationally recognized law school;
(iii) ten years of teaching tax law as an adjunct professor at two nationally recognized law schools serially; and
(iv) participation as lecturer at over 40 seminars in the past 12 years covering a wide range of topics in the tax law.
(c) Management experience as the coordinator of tax group activities in the Dallas Office of Jones, Day, Reavis & Pogue for three years, including coordinating the practice of 11 tax lawyers in a broad-based practice, coordinating recruiting efforts and making personnel decisions, and managing various major client relationships.
(d) Experience as national coordinator of the partnership tax and real estate tax practice of Jones, Day, Reavis & Pogue for four years.
(e) Extensive participation in general recruiting activities at my current and former law firms.
(f) Tax controversy and litigation experience.

PREPARED STATEMENT OF GAIL WILENSKY

Mr. Chairman and Members of the Committee: It is a pleasure for me to appear before you today as President Bush's nominee for Administrator of the Health Care Financing Administration. This morning I would like to share with you my aspirations for Medicare and Medicaid.

Mr. Chairman, it was 25 years ago this year that the Medicare and Medicaid programs were signed into law. This anniversary should renew for us the charge presented to these programs in 1965: to promote access to quality health care for the most vulnerable groups in society. Today, 34 million Medicare beneficiaries and 25 million Medicaid recipients receive necessary health care through the programs administered by HCFA. Service to these individuals will be my greatest priority as HCFA Administrator.

While I believe that the Medicare and Medicaid programs have many successes to celebrate, it will not be my job as HCFA Administrator to preside over the accomplishments of the past. As we enter the 1990s, it is time to turn our energies and our resources toward the *most* vulnerable of our day—the poor and the uninsured. As HCFA Administrator, I would direct our limited resources to benefit those least advantaged among us. I support recent legislation to expand Medicaid coverage of pregnant women and children up to 133 percent of the Federal poverty line. Through HCFA's Maternal and Infant Health Initiative, I also would encourage states to offer Medicaid coverage of pregnant women and infants up to 185 percent of the Federal poverty line.

As you may know, I have a personal interest in issues surrounding the uninsured. In this regard, I am pleased that Secretary Sullivan will rely on the HCFA Administrator to vice-chair a Departmental Task Force to explore the issues of the uninsured and long-term care. These are among our most pressing national health policy concerns. I am eager to work with my colleagues within the Department, as well as Congress, beneficiary groups, health care providers, and other industry representatives in examining these areas.

As we continue to explore these demanding issues, we must do so with a sense of seasoned caution: there are no obvious answers before us. Unlimited financial resources are not available to us. What *is* available to us, however, is our collective experience, and a desire to make progress in responding to the health care demands of needy Americans. I commit to you today that I will continue to explore the existing possibilities for solving these problems, and seek the counsel of the beneficiary community, provider groups, and others who would like to share in probing solutions to these issues. I hope to work with this Committee and its staff—as I have in other capacities—in approaching these issues of such importance to us.

The Medicare program has matured well over the past 25 years, and, no doubt, will continue to change in the years ahead. The greatest challenge will continue to be ensuring Medicare's financial solvency. As stewards of the Medicare Trust Funds, we have a responsibility to spend Medicare dollars wisely, and to pursue policies which give us more *value* for the dollars we do spend. To that end, we must continue with efforts to control the growth in Medicare expenditures, particularly Part B expenditures. I support the physician payment reform package advanced by the 101st Congress, and as HCFA Administrator, would look forward to guiding its implementation.

The physician payment reform debate highlighted for us the complexities and evolving nature of American medicine today. Physicians are striving to practice quality medicine while information surrounding the efficacy of medical treatments is often either non-existent or inconclusive. The Department's initiative to explore the effectiveness of medical practice through outcomes research will play a key role in minimizing the uncertainty that currently characterizes many medical decisions. I have no doubt that 25 years from now, we will look back to the dawning of this initiative as a turning point in the practice of medicine. I applaud Secretary Sullivan, this Committee, and the many committed medical groups involved for their leadership in this important area. I look forward to working in concert with them in pursuing it.

Beneficiaries are also caught in the middle of our evolving medical care system. They are often left confused and frustrated by the lack of coordination among the providers who serve them. New ways of delivering health care, such as HMOs and PPOs, can help beneficiaries coordinate access, and have great potential for enhancing quality as well. As HCFA Administrator, I hope to encourage movement away from "a la carte" medicine and toward coordinated care approaches.

The job of HCFA Administrator requires balancing the competing demands of the many groups HCFA serves, most especially the beneficiaries. I will do my best to

serve these groups well, and I look forward to their participation in addressing the issues facing our health care system. As we—the Administration and Congress—continue to consider the health care demands of our citizens within the means available to us, I offer you my expertise in health care, my knowledge of the Department, and my personal desire to improve the health care system in this nation. I would be honored to usher Medicare and Medicaid into their second quarter-century of service.

Thank you, Mr. Chairman. I would be pleased to answer any questions you may have.

GAIL R. WILENSKY, PH.D., VICE PRESIDENT, DIVISION OF HEALTH AFFAIRS, PROJECT HOPE

Gail Wilensky joined Project HOPE as its Vice President, Division of Health Affairs, and Director, Center for Health Affairs, in April of 1983. The Division includes the Center for Health Affairs, an interdisciplinary group of 18 professionals, and the quarterly publication, *Health Affairs*. Her primary function in these two roles has been to develop a health policy capability at Project HOPE.

Over the past five years, Dr. Wilensky has directed numerous studies including ones on developing affordable health insurance strategies for the employed uninsured, the relationship of financing to the diffusion of technologies, the impact of an increasing physician supply and the effects of the prospective payment system. She was the project director of a Department of Health and Human Services cooperative agreement under which HOPE provided support to all aspects and phases of Secretary Bowen's study of catastrophic illness. She has also recently directed a study on the relationship between prospective payment and the nursing shortage and led a project group providing technical assistance to Secretary Bowen's Commission on Nursing.

Dr. Wilensky has published many articles in the field of health economics and health policy, including both professional and popular journals. She is a frequent speaker before health professional and employer groups on a wide variety of health related topics and has testified before Congress on many occasions. In May of 1989, she was appointed to the Physician Payment Review Commission. She is also a member of the Institute of Medicine, National Academy of Sciences.

Dr. Wilensky is a nationally recognized expert on the problems of the uninsured and has written and spoken extensively on this subject. She recently received The 1989 Dean Conley Award from the American College of Healthcare Executives for her article "The Uninsured: Response and Responsibility."

Dr. Wilensky came to Project HOPE from the National Center For Health Services Research, where she co-directed the multimillion dollar National Medical Care Expenditure Survey. She has held faculty appointments at the University of Michigan and George Washington University and a senior research appointment at the Urban Institute. Dr. Wilensky received her Ph.D. in Economics from the University of Michigan.

SENATE FINANCE COMMITTEE CONFIRMATION

OUTLINE OF INFORMATION REQUESTED OF

GAIL ROGGIN WILENSKY
2807 Battery Place, NW
Washington, DC 20016

A. BIOGRAPHICAL:

1. Name:

Gail Roggin Wilensky; (nee) Gail Susan Roggin

2. Address:

2807 Battery Place, NW
Washington, DC 20016

3. Date and place of birth:

June 14, 1943; Detroit, Michigan

4. Marital status:

Married; Robert Joel Wilensky, M.D.

5. Names and ages of children:

Peter Benjamin, age 20
Susan Elizabeth, age 18

6. Education:

University of Michigan; 1960 - 68:
BA 1964
MA 1965
PhD 1968

7. Employment record:

Jan 1968 - Aug 1968
Research Associate, Dept. of Economics,
University of Michigan,
Ann Arbor, Michigan

Sept 1968 - Sept 1969
Staff Economist, President's Commission
on Income Maintenance Programs,
Washington, DC

Sept 1969 - Dec 1970
Executive Director, Governor's Council of
Economic Advisers,
Baltimore, MD

Jan 1971 - June 1973
Senior Research Associate,
Urban Institute,
Washington, DC

Sept 1973 - June 1975
Associate Research Scientist,
Institute of Public Policy Studies, and
Visiting Assistant Professor of Economics,
University of Michigan,
Ann Arbor, Michigan

July - August 1974
July - August 1975
Faculty Associate, Survey Research Center,
University of Michigan,
Ann Arbor, Michigan

Sept 1975 - Sept 1978
Health Service Fellow
Sept 1978 - Apr 1983
Senior Research Manager
National Center for Health Services
Research, DHHS,
Rockville, MD

Sept 1976 - Apr 1978
Associate Professional Lecturer,
Department of Economics,
George Washington University,
Washington, DC

Apr 1983 -
Vice President, Division of Health Affairs
Project HOPE,
Chevy Chase, MD

8. Government experience:

See employment history for jobs with Federal government and State of Maryland;
Member, Maryland Medicaid Commission, Comprehensive Health Care Subcommittee, May-August 1972;
Consultant, Bureau of Health Resources Development, DHEW, April 1973 - April 1974;
Consultant, National Center for Health Services Research, DHEW, June 1974 - July 1975;
Consultant, District of Columbia Tax Revision Commission, Sept. 1976-June 1977;
Member, National Committee on Vital and Health Statistics, DHHS, Oct. 1986 - Feb. 1988;
Member, Health Advisory Committee, Comptroller General of the US, 1987-;
Member, Physician Payment Review Commission, May 1989-.

9. Memberships:

Member, American Economic Association,
Member, National Tax Association,
Member, American Public Association,
Member, Association for Health Services Research
Member, Institute of Medicine,
Member, Smithsonian Associates,
Member, Georgetown Day School Parents Club,
Member, Amherst Parents Club,
Member, Harvard-Radcliff Parents Club,
Member, St. Albans Tennis Club,
Member, Sport and Health Club,
Member, Adas Israel Synagogue and Sisterhood,
Member, Hadassah,
Member, University of Michigan President's Club; Alumni Association

10. Political affiliations and activities:

Registered Democrat 1979 - 1983
Registered Republican 1983 -

Informal health policy advisor to Bush Campaign, Dec 1987 - Nov 1988;
Ongoing relationship with House Wednesday Group, May 1988 - ,
briefings, position papers;
Contributions to:
Womens Campaign Fund, early 1980s
GOPAC, 1987
Bush Campaign, 1988

11. Honors and Awards:

Elected Member, Institute of Medicine, National Academy of Sciences;
Who's Who in America;
Who's Who of American Women;
World's Who's Who of Women;
1989 Dean Conley Award (outstanding article), American College of Health Care Executives;
Flinn Foundation Distinguished Scholar in Health Policy and Management, Fall 1986;
Alumna in Residence Award, University of Michigan, Spring 1989

The Honorable Alan J. Dixon
United States Senate
Washington, D.C. 20510

Dear Senator Dixon:

I have reviewed your list of questions concerning administrative appeals procedures for Medicare decisions. As I am sure you are aware, such appeals are now processed by administrative law judges (ALJs) and by the Appeals Council within the Social Security Administration (SSA).

I am advised that there has been very thorough and detailed consideration of the resolutions of the Illinois State Bar Association and the American Bar Association concerning administrative proceedings within the Department of Health and Human Services. Indeed, as recently as October 31, 1989, Secretary Sullivan responded in writing with his views.

To reiterate them, the Secretary noted that, since July of 1988, the Office of Hearings and Appeals (OHA) within SSA has indexed and made available to the public final decisions, including dismissals, made by its ALJs and by the Appeals Council for all adversarial Medicare and Medicaid cases heard after October 1, 1987. This Index of Adversarial Health Insurance Decisions and Dismissals is published and available for review by the public in each Social Security office. Since initial publication, there have been only two requests for documents listed on the index.

Most appeals fall outside the adversarial type and are fact-specific cases brought by individual beneficiaries. The Department's long-standing position, based upon the legislative history of the Freedom of Information Act (FOIA), is that the FOIA requires indexing and publication of only those decisions which are precedential, not every decision issued by the SSA ALJs and the Appeals Council each year. This position is reflected in 20 C.F.R. 422.408. Those decisions, which the Department considers to have precedential value, are indexed and published separately as Rulings of the Commissioner of Social Security or as Rulings of the Health Care Financing Administration (HCFA). The cost of indexing and publishing every ALJ and Appeals Council decision would be well in excess of $10 million per year.

Concerning the suggestion that there be published regional and central dockets of all cases on appeal, there is nothing in the FOIA that requires this. There are no plans within the Department to publish such lists. Nor is there any plan to establish more comprehensive rules of procedure for any of the various classes of HCFA administrative proceedings; however, we will be reviewing regulations applicable to certain types of proceedings where those regulations are outdated or require clarifications or other improvements.

Finally the Secretary has stated that it would be inappropriate to publish all manuals in the Federal Register. Such publication would not only raise these operational manuals to the level of regulations, but would greatly impede the ability of the Department to respond quickly to changing needs and requirements within the Medicare and Medicaid programs.

In closing, I would like to add that I am aware that the Administrative Conference of the United States has undertaken a broad study of administrative proceedings conducted by all Federal agencies. One of the questions they will address is what kinds of agency decisions should be indexed. I believe that once this study is completed, it would be appropriate to review the HCFA administrative appeals requirements.

Sincerely,

/s/

Gail R. Wilensky
Administrator-Designate

RESPONSES OF DR. WILENSKY TO QUESTIONS FROM SENATOR BENTSEN

Question. We are currently paying for hospital capital under Medicare at 85% of costs. Some proposals would make an even larger reduction to those hospitals with relatively low occupancy rates. Given that occupancy rates average about 65% overall, and less than 40% for small rural hospitals, I'm interested in your comments on this concept. More generally, what are your thoughts about the addition of capital into the Prospective Payment System (PPS) which is scheduled to begin in fiscal year 1992? When can we expect to see the Administration's proposal?

Answer. HCFA believes that a prospective payment system for capital payments is preferable to one based on occupancy rates, because it provides the most appropriate incentives in paying for capital-related costs.

An occupancy adjustor would only penalize hospitals for excess capacity. We believe that folding capital into PPS creates positive incentives for the efficient use of capital.

Ultimately, inclusion of capital costs in the PPS payment rate is the best way to contain capital costs and provide appropriate incentives to manage capital expenditures. In order to allow extensive time for public input into the rulemaking process, we are planning to issue our proposed rule later this year for incorporating capital into PPS in FY 1992.

As stated in the President's Budget, in the event that prospective payment for capital is delayed, the Administration would favor an alternate adjustment to capital payments to provide similar incentives.

Question. Medicare payments for hospital *outpatient* services rose from about $2 billion in 1980 to about $7 billion in 1988, a 350 percent increase. While for inpatient services, we pay hospitals under a prospectively fixed rate, outpatient services are subject to a variety of payment methods depending on the service. These include a fee schedule for lab services and ambulatory surgery payments that blend the hospital's costs with rates paid to freestanding ambulatory surgery centers. About 20 percent of Medicare payments for outpatient hospital services are paid purely on the basis of hospital costs.

The Department of HHS is required by the beginning of next year to develop a proposal for a model prospective payment system for hospital outpatient services. Are you optimistic that a comprehensive outpatient payment system can be developed from what is now a very fragmented set of payment methods? Would you describe how you think such a proposal would be structured?

Answer. HCFA shares the concern of the Congress about the growth in expenditures for outpatient services. The issues are complex and warrant close examination.

Expenditures for outpatient services are one of the fastest growing components of the Medicare program. An increase in the volume of outpatient services is primarily responsible for this increase in expenditures. And, while a portion of the increase in volume can be attributed to the general trend toward providing services in the outpatient setting rather than the inpatient setting, research indicates that much of the outpatient volume increase is unexplained.

HCFA has undertaken substantial research and development activity to support the design of a prospective payment system for ambulatory care, as required by law. HCFA is constructing a classification system called Ambulatory Payment Groups which could serve as a model payment system for the facility portion of hospital-based ambulatory care. Ambulatory Payment Groups group patients who utilize similar resources. Surgical services, non-surgical services and ancillary tests are included in the Ambulatory Payment Groups.

HCFA is currently evaluating various aspects of implementing Ambulatory Payment Groups, as well as other alternative outpatient payment options. The results of this evaluation will be included in a report to Congress (due January 1991) on the use of an outpatient payment system.

Question. One of the biggest health financing issues is finding a way to help those without health insurance. While a comprehensive solution will need to go beyond the Medicaid program, we have expanded Medicaid eligibility for pregnant women and children in recent years as a way to target assistance to that particularly vulnerable population. What kind of commitment can we expect from you regarding improved coverage for the uninsured?

Secretary Sullivan has made it known that he supports further Medicaid expansions to 150% of poverty for pregnant women and infants, a proposal I understand did not pass muster at the OMB. I know you have worked on this issue in your capacity as a health researcher. What kinds of proposals to improve Medicaid might we expect from you in the future?

Answer. I share your concern about finding a way to help those without health insurance. In September 1989, the Secretary announced the establishment of a Departmental task force under the leadership of the Under Secretary to develop recommendations to assure adequate health care coverage for the uninsured. I am pleased to serve as Vice-chair of this task force. Among the options being explored are proposals to allow low-income, employed individuals to buy Medicaid coverage, and to encourage States to develop State risk pools for individuals with serious preexisting health conditions. I also want to review the recommendations of the Pepper Commission and the Advisory Council on Social Security.

Concerning Medicaid expansions, I will continue to encourage States, through the HCFA Maternal and Infant Health Initiative, to pursue programs which increase medical coverage for this vulnerable population. The health of pregnant women and infants is a top priority of the Administration and I share this commitment. The goal of HCFA's initiative is to bring more low-income, eligible pregnant women into early prenatal care; bring more infants into continuing health supervision; improve program coordination among Medicaid, MCH, and WIC; and, track progress and assess accomplishments.

The President's FY 1991 proposals would improve access to services for Medicaid eligible individuals by lengthening the period of presumptive eligibility for pregnant women; by allowing States to provide a full range of services that are available to AFDC recipients to all categorically needy pregnant women; and, by requiring States to have laws governing private health insurance coverage for children under the insurance policies of their non-custodial parents.

Before considering further Medicaid expansions, it is important to examine the effect recent Medicaid expansions have had on the program. States need time to implement the changes permitted by recent legislation. In the meantime, States already have the option to expand coverage for pregnant women and infants up to 185 percent of the poverty line. Indeed, fifteen States are providing this coverage now, and four more have implemented coverage up to 150 percent of the poverty line.

Question. In the last reconciliation bill, Congress agreed to the Administration's proposal to limit the amount Medicare will pay for home dialysis services under the so called "Method II" reimbursement system.

At my insistence, the effective date of the rate change was delayed until February 1 in order to allow beneficiaries time to find alternative providers where necessary.

I have been hearing from beneficiaries who are extremely concerned because the company that is currently servicing them say it will no longer do so at the new payment rate.

While some patients will be able to travel to a treatment facility, it may be extremely difficult for others to leave their homes.

What steps has Medicare taken since November to identify patients with special needs?

What criteria are you using to identify patients requiring special assistance?

Once you identified a patient with special needs, what are you doing to ensure that life-service is not interrupted?

Answer. HCFA made a concerted effort to ensure that any Method II beneficiary whose supplier withdrew services was not be left without dialysis services on February 1, 1990. On December 14, 1989, we sent a letter to each individual whose dialysis benefit would be affected by the OBRA 89 End Stage Renal Disease (ESRD) provisions. The letter described the changes made by the new legislation, and outlined treatment options available to beneficiaries. Names and phone numbers of HCFA regional office staff were included in the letter, and patients experiencing difficulty locating dialysis services for February 1 were advised to contact the regional office.

The letter was followed up by personal phone calls from regional office staff and from ESRD Network personnel. For patients who could not be reached by phone, HCFA sent certified, return-receipt-requested letters urging the patient (or family member, neighbor, or physician) to contact HCFA immediately about arrangements for continued dialysis services. In some cases, personal visits to the homes of dialysis patients were made.

The very large majority of patients are now receiving dialysis treatment at Medicare-approved dialysis facilities. However, HCFA regional office staff, in consultation with ESRD networks, determined that certain "hardship" cases warranted special attention. As a result, HCFA made special arrangements for approximately 60 beneficiaries to continue to receive care after February 1, 1990, under the Secretary's experimental authority provided in the law. Under this authority, we will provide staff-assisted dialysis in beneficiaries' homes for 90 days until other arrangements can be made to satisfy their specific needs.

Question. As a former member of the Physician Payment Review Commission (PPRC) you are undoubtedly familiar with the many issues involved in implementing the new physician payment system approved by Congress last fall. As HCFA Administrator, you will be responsible for actually putting the new system in place.

What are your views on eliminating specialty differentials, that is, paying a specialist more to provide a service than a general practitioner is paid for the same service?

Answer. The Medicare physician payment reform package, enacted in OBRA 89, contains a provision prohibiting the Secretary from varying the number of relative value units or the monetary conversion factor based on the specialty of the physician performing the service.

Question. There has been considerable discussion about establishing separate volume performance standards, either by specialty or geographic region, by which to evaluate the growth in spending for physicians' services, either by specialty or by geographic region.

Do you believe that separate standards are desirable, and, if you do, when do you believe that it will be technically feasible to do so? In other words, do you think that a national standard is the first step toward smaller, more specific specialty or geographic standards?

Answer. OBRA 89 requires that, for years after FY 1990, a separate performance standard rate of increase be established for surgical services and other categories of physician services as may be defined by the Secretary.

There are numerous technical and operational issues that must be explored in determining just how separate standards could be developed. I intend to undertake a thorough examination of these feasibility issues in the next few months.

Question. It has been reported in the press that Medicare is about to publish a long-delayed final rule on payment rates to ambulatory surgery centers. Can you confirm that report?

In its proposed rule on this subject, Medicare proposed to pay a flat $200 for any lens that is implanted during cataract surgery.

Manufacturers of these lenses tell us that this amount is inadequate for so-called "new technology" lenses and that it will discourage the adoption of better products into medical practice.

Do you agree with the view that more sophisticated lenses are needed by some patients, and what, in your view, should be done to ensure that patients are able to obtain the type of lens they need—even if it costs a little more?

Answer. That report is correct. The final rule updating ambulatory surgery center rates was published in the *Federal Register* on February 8.

The data that we have collected, analyzed, and audited over the past four years supports a single $200 payment for intraocular lenses which are implanted during cataract surgery for Medicare beneficiaries.

HCFA has repeatedly solicited evidence in an attempt to demonstrate that one type of lens is more beneficial to Medicare recipients than another type. However, analysis of the information indicates that the medical benefits of various lens types are equivalent. Further, the Food and Drug Administration also has advised HCFA that the all lenses are equally effective.

Because of the high volume of cataract procedures involving insertion of intraocular lenses, we will continue to review our payment policy with respect to intraocular lenses. If a change in policy is warranted, HCFA will publish a notice in the *Federal Register* and solicit comments.

Question. In your tenure at Project Hope, you were involved in developing a research project in which only selected providers would be designated by Medicare to provide heart bypass surgery.

I understand that Medicare is currently developing a proposal under which a limited number of providers would be designated as "preferred providers" of cataract surgery.

Do you think that such a system would improve the quality of care for cataract patients?

Is there any danger that such an approach will actually increase the number of cataract surgeries, as facilities that are not designated as preferred providers compete for business with those that are?

If reducing program expenditures is the objective of this project, hasn't Congress already taken steps to address this concern through reductions in reimbursement for "overvalued" procedures and the adoption of the Physician Payment Reform package?

Answer. The cataract surgery demonstration is in the design stage. The demonstration is intended to examine all aspects of cataract surgery, including appropri-

ate indications for the surgery and the desirability of "bundling" Medicare payment (that is, having a set price for the procedure, including pre- and post-operative care).

The primary objective of this demonstration is to study utilization and payment methods for this particular procedure. However, to the extent that the demonstration brings forth better approaches to assuring *appropriate* utilization, quality will undoubtedly be enhanced. And, because utilization trends will be carefully monitored, it is unlikely that the demonstration would result in an increase in the volume of cataract surgery.

OBRA 89 reduced Medicare payments for "overvalued" procedures, including cataract surgery. However, this demonstration will look at all aspects of this procedure, not merely its price. Cataract surgery was the most frequently performed surgical procedure on Medicare beneficiaries in 1988, costing Medicare a total of $2.5 billion. This demonstration will help us better understand the best approaches to assuring that cataract surgeries performed on Medicare beneficiaries are medically necessary and cost-effective.

Question. As you know, more than two years ago, Congress required the HHS Inspector General to promulgate so-called "safe harbor" regulations to protect legitimate business practices under the Medicare "anti-kickback" laws.

While final regulations have not yet been issued, the proposed rules, which were published early last year, took a restrictive view of practices—such as volume discounts—that are common in other sectors of the economy.

Are you concerned that these rules may place at risk practices that will save the program money?

Answer. I will have to defer to the Inspector General, whom I know is taking an extremely thoughtful and thorough approach in developing the safe harbor regulation. This is a complex issue, and caution must be exercised so that potentially harmful situations are prohibited and quality protected.

As you know, the intent of the anti-kickback legislation is to prohibit overutilization caused by improper referrals and financial arrangements, not to restrict practices that save money. In creating safe harbors, the Inspector General's regulation attempts to separate practices which have a positive benefit from those which do not. Consequently, volume discounts designed to induce referrals would be prohibited, but other discounts could be permitted under circumstances primarily intended to contain costs.

I am sure that in finalizing these regulations, the Inspector General will protect against fraud and abuse while permitting as many legitimate business practices as can be accommodated.

Responses of Mr. Wilensky to Questions From Senator Mitchell

Question. A number of important Medicare expansions in the area of long-term care were lost with the repeal of the Medicare Catastrophic Coverage Act (MCCA). One such provision, which had the full support of all Members of this Committee lifted the 210 day limit on the Medicare hospice benefit.

As part of the transition, grandfather provisions for the hospice and SNF benefits were enacted. Apparently, HCFA is interpreting the grandfather provision for the hospice benefit in the most restrictive way possible. HCFA's interpretation would grandfather only those hospice patients who had already exhausted the 210 day limit prior to the repeal of MCCA.

This interpretation is not consistent with the grandfather provision for the SNF benefit, which allows SNF patients to receive the full 150 days regardless of whether they have passed the 60 day limit of the original Medicare SNF benefit.

I believe that HCFA's current interpretation of the grandfather provision for hospice is inequitable. What is your rationale for this interpretation?

I strongly urge you to reexamine the interpretation of the grandfather clause for the Medicare hospice benefit and allow all hospice patients who were receiving benefits before the repeal of MCCA to continue to receive those benefits indefinitely.

Answer. By our interpretation, the law does not permit all hospice patients who were receiving benefits before the repeal of the Medicare Catastrophic Coverage Act of 1988 (MCCA) to continue receiving those benefits indefinitely. MCCA added a fourth election period for hospice, to be used after the initial three election periods had exhausted the 210-day limit. This fourth election period was designed to be indefinite in length. The MCCA repeal only removed this fourth election period. Therefore, only those individuals who had already elected, before January 1, 1990, the fourth, indefinite period will be allowed to continue. All others hospice patients are subject to the original 210 day limit.

Question. As you know, I have been actively involved with the development and enactment of Effectiveness Research legislation in the Senate and have worked to increase the amount of funding appropriated for this program in the FY 90 Appropriations. Further, I was instrumental in crafting the relationship between the outcomes assessment research to be done in the Public Health Service and the need for information and coordination with Medicare physician payment reform. How will you, as HCFA Administrator, work with the public Health Service to coordinate the Effectiveness Initiative within the Department and ensure that the initiative is successful? Further, how will you ensure that the priorities of Medicare are reflected in the research agenda and the development of practice guidelines?

Answer. I have a great personal interest in seeing that the effectiveness initiative is successful. While overall responsibility for the effectiveness initiative rests with the public Health Service, it is an effort which requires the talents and resources of many Department components, including HCFA. Because of the great potential effectiveness research has for improving the quality of care rendered to Medicare beneficiaries and Medicaid recipients, and because the effort will be funded by the Medicare trust funds, HCFA continues to work closely with the Public Health Service on this important initiative. Indeed, the effectiveness legislation included in OBRA 89 contains a provision requiring that effectiveness research priorities be set in consultation with the HCFA Administrator to assure that the priorities of the Medicare program are reflected in the overall research agenda. I am committed to promoting the success of this vital effort and look forward to working with my colleagues within the Department in pursuing the Effectiveness Initiative.

Responses of Dr. Wilensky to Questions From Senator Pryor

Question. Many hospitals and HMOs employ preferred drug lists, or formularies, as a bargaining tool to negotiate with drug manufacturers for better drug prices. To date, State's attempts to stem spiraling Medicaid drug program costs by trying to emulate the private sector and negotiate directly with drug manufacturers have been futile. In fact, while prescription drug expenditure increases have outpaced virtually all Medicaid-covered services, the only thing States have been successful at is reducing the local pharmacist's reimbursement. It is no secret that the sick and poor members of our society, pharmacists, State Governments are extremely frustrated, as I am, with this situation. In fact, I plan to introduce legislation that would provide much needed assistance in this regard.

a. Could you further elaborate on my concerns about increasing cost burdens on State prescription drug programs?

b. Do you believe that a list of preferred drugs that would assure physicians that they could prescribe any off-formulary drug if they believed it was medically necessary could be a valuable tool for controlling Medicaid drug program costs, and would you support a proposal based on this concept?

c. What role is there for the Federal Government in assisting the States in becoming more prudent purchasers of drugs? If so, what role do you believe the Federal Government should play in accomplishing this?

Answer. a. Generally, I agree with your assessment of the situation. Since the Medicaid Drug Program is based on payments to the providers of the service (pharmacists), this is the point where some efforts can be successful in controlling costs. However, this does not get to the root of the problem in that the spiraling costs are primarily a result of the continually increasing cost of drug ingredients. As you know, these costs have outpaced the inflation rates as indexed by the Consumer Price Indices for Medical Care and Services for the past several years. The manufacturers of these drug products are the sole source of the product as well as the sole determinant of the prices that wholesalers or pharmacists pay for those products. There is no basis or authority in the Medicaid program that would allow for any controls on manufacturer pricing.

b. Medicaid coverage of prescription drugs is an optional service. States therefore have discretion to decide which drugs they want to cover, except for those drugs that are determined by the FDA to be less than effective.

If a "Medicaid formulary" involved the establishment of a list of preferred drugs, coverage of individual drugs would still be left to the discretion of the State. While the use of this formulary to obtain the drugs directly from manufacturers at a reduced cost may be an effective means of reducing program costs, we are concerned about how the list would be established or administered at the national level.

On the other hand, if a "Medicaid formulary" involved the establishment of a national formulary for Medicaid drug programs, this would constitute mandatory cov-

erage by States. We foresee several difficulties in the establishment and administration of the list in this situation as well. But more significantly, it would eliminate State flexibility in a very expensive area of Medicaid coverage policy.

c. We do not believe there is a direct role for the Federal government in assisting the States in becoming more prudent purchasers of drugs. First, as I mentioned before, there is no basis or authority in the Medicaid program that would allow for any control on manufacturer pricing. Second, Medicaid coverage of prescription drugs is an optional service; therefore, State Medicaid prescription drug programs vary widely in their coverage of drugs.

In the event that statutory or regulatory modifications would be needed to allow States to demonstrate specific prudent purchasing approaches, the Federal Government may wish to play a more active role.

Question. During the debate leading to both enactment and repeal of the Catastrophic Coverage Act, it became abundantly clear that senior citizens, and their families, are very confused about what's covered and not covered under Medicare. Beyond the complexities of Medicare and Medicaid, decision-making about private coverage—Medigap, long-term care insurance, and other forms of health care coverage—is exceedingly difficult for most people. *What can the Federal Government do to make it easier for beneficiaries to understand their health care insurance needs and to make informed and prudent choices about what private polices they may or not need?*

Answer. HCFA is working to assure that Medicare beneficiaries are informed about how changes in catastrophic coverage affect their Medigap policies. These issues are discussed in the upcoming 1990 editions of the *Medicare Handbook, The Guide to Health Insurance for People with Medicare,* and in a special message mailed in January to all Medicare beneficiaries explaining the major changes in the Medicare program for 1990.

These changes are also addressed in a packet of information distributed to the media throughout the country and through toll-free number maintained by HCFA to provide the public with information about revisions in the Medicare program.

We will begin distributing *The Guide to Health Insurance for People with Medicare* in March and the *Medicare Handbook* in May. The Handbook, which provides a comprehensive explanation of the Medicare program, will be mailed to all Medicare beneficiaries. The Guide, which explains the different types of insurance available to Medicare beneficiaries and what they should look for in a policy, will be available at local Social Security Administration offices, State departments of insurance and agencies on aging, and the Consumer Information Center in Pueblo, Colorado.

Question. In light of the misunderstandings so many older persons have about their health insurance needs and coverage, and their vulnerability to high pressure, and even unscrupulous, sales practices, I intend to offer legislation to ensure that beneficiaries have access to knowledgeable individuals who can counsel them on their health insurance needs and purchases. *Is this a concept that you support?*

Answer. Certainly this idea has merit. However, I would like to see the proposal before I comment further.

Question. OBRA 87 contained the most important reforms in Federal law to alleviate inadequacies in nursing home quality requirements and the enforcement of those standards. In May 1989 I conducted a hearing of the Special Committee on Aging to examine why HCFA had failed to meet *every statutory deadline* in OBRA 87. At that hearing, HCFA promised proposed regulations in the *Federal Register* by August 1, 1989. Here we are, over two years after enactment, and not a single OBRA 87 required regulation has been offered, much less finalized. *What assurances can you offer that implementation of these widely hailed reforms is a priority of the Administration?*

a. Most of the key features of OBRA 87 are scheduled to take effect October I, 1990. When can we expect the publication of proposed regulations so that States, providers, and nursing home residents will know what is expected under law?

Answer. I want to assure you that HCFA views nursing home reform as one of its highest priorities, and continues its efforts to implement these provisions appropriately. I also want to affirm this commitment to the Medicare and Medicaid beneficiaries in nursing homes who look to us to protect their rights and the quality of care they need.

This protection has been our fundamental goal as we developed policies to implement reforms in nursing home quality. For example, we sought many, and often conflicting, points of view in the development of our February 2, 1989 final regulations and other guidelines that we have issued to implement OBRA 87 nursing

home reform. This consultative process is by its very nature time-consuming, but I believe it will result in the best possible quality standards to protect patients.

At the May hearing, I understand discussion focused on the fact that the effective dates established in OBRA 87 could not realistically be met. Congress included specific deadlines and requirements in OBRA 87, many of which became operational regardless of whether the Department had issued regulations. Meeting the deadlines would have necessitated publishing proposed rules almost simultaneously with the enactment of OBRA 87.

However, I want to point out that, since the enactment of OBRA 87, we have worked extensively with consumers, nursing home industry representatives and State survey agencies to develop the survey guidelines and procedures for enforcing these requirements. Since the timeframe between the publication of the requirements (February 2) and the initial effective date (August 1) was viewed as not sufficient to allow the surveyors to absorb the new information and make critical compliance decisions, last July, after extensive discussions with the States, consumer group advocates, and nursing home industry representatives, we delayed the effective date of the regulations until January 1, 1990.

I've been informed that, at your request, HCFA staff met with your staff to discuss more realistic due dates. During the FY 1990 budget reconciliation negotiations, nursing home reform issues were debated and included in various versions of the legislation. Indeed, the conference agreement delayed the effective dates for the major nursing home regulation and nurse aide training requirements.

In addition, OBRA 89 requires us to publish proposed regulations for Preadmission Screening and Annual Resident Review (PASARR) nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs by March 19, 1990. Both of these regulations were published in the *Federal Register* on March 23, 1990.

a. At the same time the Congress was undertaking nursing home reform legislation, HCFA had drafted rules to improve nursing home quality. Since there were important differences in the OBRA 87 legislation and our proposed regulation, we moved quickly to establish a unified set of nursing facility requirements. On February 2, 1989, we published final regulations (soliciting comment in response to the continuing concerns of Congress and consumers) to revise and consolidate the requirements that facilities furnishing long-term care must meet to participate in both the Medicare and Medicaid programs.

We have reviewed the more than 800 comments we received on the February 2 regulation and are preparing another final regulation for publication later this year to be effective on October 1, 1990, the new date required by OBRA 89.

With regard to nurse aide training and competency evaluation programs, HCFA consulted widely with the States, the industry, consumers, advocates and Congressional staff before issuing guidelines in the State Medicaid Manual in April 1989. We handled Preadmission Screening and Annual Resident Review (PASARR) in a similar manner. Draft criteria were made available to the States and others at the beginning of September 1988. After much consultation with advocates, the industry, beneficiary representatives and the States, HCFA issued the State Medicaid Manual Instructions in May 1989. These criteria were published as a proposed regulation in the *Federal Register* for comment on March 23, 1990.

Question. A major key to providing high quality care and meeting the letter and spirit of the OBRA 87 law, is the availability of adequate numbers of trained staff in nursing homes. Yet, many argue that the nurse shortage is a major impediment to accomplishing this. As HCFA Administrator, what do you intend to do to address the staffing problems associated with long-term care?

Answer. While at Project Hope, I worked closely with the Secretary's Commission on Nursing. The report issued by the Commission challenges all leadership organizations, both in government and in the private sector, to address the causes of the nurse shortage and to pledge their commitment to solving them.

Other agencies in the Department are more directly involved in addressing this issue. However, as HCFA Administrator I am hopeful that the supply of nurses will respond positively to the demand for them.

For example, nursing home reform may have a positive impact on this shortage over the long run. To meet the 24-hour nursing requirement, facilities' administrators will have to devise incentives to recruit and retain qualified nurses on their staffs. A separate provision in OBRA 87, clearly stated in our February 2 regulation, requires States to increase payments to nursing facilities to meet the additional requirements of the law. We believe that the implementation of these requirements

may well provide the basis for additional real demand for nursing services and that this demand will result in an increase in the number of individuals entering nursing and the long-term care field.

Question. It is my understanding that the OMB has proposed to cut HCFA's FY 91 budget request for nursing home survey and certification activities by $273 million and proposed to have nursing homes pay for these functions through user fees. Some State regulators and consumer groups see this proposal as opening the door to privatizing the nursing home inspection process, by allowing private accreditation bodies to serve the function of government regulatory bodies. As you know, in the early 1980s, widespread opposition to the Administration's proposal to allow "deemed status" led to the OBRA 87 reforms. What is your position on such an approach, and do you believe HCFA and the States can carry out their responsibilities if the survey and certification budget is cut?

Answer. Our FY 1991 budget proposal would create a user fee system to support the survey and certification process for all providers and suppliers in the Medicare and Medicaid programs, not only nursing facilities. It is similar to the approach Congress employed in December 1988, when it created a user fee system to finance the certification of clinical laboratories under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). This user fee system creates a "pay as you go" basis for those providers and suppliers who benefit from participation in the Medicare and Medicaid programs. The most attractive feature of the proposal is that the fees assessed can be adjusted to reflect the real costs of the inspection process, thereby insuring adequate funds to administer the program on an ongoing basis.

This proposal does not establish a vehicle to "privatize" the survey and certification system. In 1984, the Congress did provide the Secretary with the authority to grant "deemed status" under the Medicare program to nursing facilities accredited by non-profit accrediting organizations whose programs are approved by Medicare. However, no accrediting organization has yet applied for Medicare approval to deem nursing homes in compliance with Medicare requirements. The authority to deem through private accrediting organizations does not exist for Medicaid nursing facilities.

Also, I want to note that under CLIA, the Congress outlined how the Department could deem private non-profit accreditation organizations and States' licensure programs, so that any laboratory accredited or licensed by an approved program would be deemed to meet CLIA 88 requirements.

Finally, the proposal in no way represents a cut in survey and certification funds and in fact, represents a substantial increase in funds to handle the expected increase in workload resulting from the implementation of nursing home reform legislation.

Question. As you know, the debate over the catastrophic care act underscored the elderly's—and the Congress'—belief that a more comprehensive approach to long-term care is needed. As the Pepper Commission moves toward completing its mandate, what priorities would you advise Congress to follow in establishing a long-term care program?

Answer. I recognize that the growing demand for and cost of long-term care emphasize the need for long-term care policy reform. I believe nursing home care, home health care, and home and community-based services are key components of any future long-term care system, however financed. In September 1989, the Secretary announced that the Under Secretary would lead a Department task force that would prepare recommendations on the important problems of long-term care and health care coverage for the uninsured. I serve as Vice-chair of this task force which is scheduled to issue its recommendations this Fall. I also want to review the findings of both the Pepper Commission and the Advisory Council on Social Security.

Question. Many people are put off—even hurt—by the bureaucracy and the complexity at HCFA, particularly, of course, in Medicare and Medicaid. They are confused, frustrated, and even angered by the complexity of the forms, by the billing procedures, and overall technicalities of health care and health care financing. How can we simplify things at HCFA and in the Medicare and Medicaid programs—particularly the forms that beneficiaries must fill out?

Answer. Indeed, health care financing today *is* a complex process, and an enormous undertaking. For example, the Medicare program alone processes claims for over one *billion* health services each year for 34 million Medicare beneficiaries. While HCFA makes every effort to minimize the complexity of claims processing from the beneficiary's perspective, the fee-for-service payment system by its very nature is somewhat of a culprit in perpetuating cumbersome paperwork and complex rules.

HCFA continually searches for methods to reduce the paperwork burden on beneficiaries. HCFA's two most burdensome forms (HCFA-1500 and HCFA-1490, Health Insurance Common Claims Form for Medicare and Medicaid) have been revised to eliminate any HCFA data requirement that is not essential to processing claims for proper payment.

HCFA assists beneficiaries during the claims process in a number of ways. For example, Medicare currently is testing a telephone system designed to help beneficiaries learn the status of their Medicare claims. Medicare's Automated Telephone Response System will answer basic questions concerning routine claims, thereby freeing up claims representatives to assist beneficiaries with problem claims. The system is being pilot tested in ten states prior to national implementation. In addition, Medicare participating physicians currently are required to submit all bills to Medicare for beneficiaries. Further, OBRA 89 requires that, beginning September 1990, *all* physicians must submit Medicare claims for beneficiaries. I also would encourage beneficiaries to take advantage of the coordinated care alternatives that the Medicare and Medicaid programs offer, including HMOs and PPOs. Coordinated care systems impose far fewer paperwork and other requirements than traditional fee-for-service, and often provide beneficiaries with more and better coordinated benefits.

Responses of Dr. Wilensky to Questions From Senator Riegle

Question. The President last year discussed the idea of allowing people without insurance to "buy-in" to the Medicaid program. I know that you have also advocated this approach at one point. As Administrator, would your plans include developing a "Medicaid Buy-in" proposal?

Answer. You may know that 1 am serving as Vice-chair of a Department task force, led by the Under Secretary, that is preparing recommendations for the reform of our health care financing policies. Among the options being explored to improve coverage for the uninsured are proposals to allow low-income, employed individuals to buy Medicaid coverage.

Question. President Bush has previously (during his campaign) stated that he supported expanded Medicaid for children below the Federal poverty level. Would you support this expansion for this country's most vulnerable citizens?

Answer. OBRA 89 expanded coverage for children under age 6 up to 133 percent of the Federal poverty level. This was similar to the President's proposal in the Medicaid Pregnant Women, Infants and Children Amendments of 1989.

We have not proposed any further expansions for FY 1991 because States need time to implement the many new expansions enacted in recent years. However, we will continue to encourage States to implement Medicaid options including coverage of pregnant women and infants up to 185 percent of poverty, and to encourage coordination of and access to services through HCFA's Maternal and Child Health Initiative.

Responses by Dr. Wilensky to Questions From Senator Rockefeller

Question. In 1987, Congress enacted legislation that provided for reimbursement of services provided by psychologists to Medicare beneficiaries at community mental health centers and rural health clinics. This past year, Congress further recognized that many Medicare beneficiaries were unable to obtain access to needed mental health care because of where they lived—particularly beneficiaries living in rural areas—because of the maldistribution of eligible mental health care providers. As a result, Congress passed legislation that allowed reimbursement for mental health services provided by psychologists and clinical social workers. I understand that the Health Care Financing Administration is currently drafting regulations to implement this new law. It is my hope that HCFA would not draft regulations that would in any way limit this important mental health benefit by, for example, attempting to limit the setting in which psychologists may treat Medicare beneficiaries and receive reimbursement for their services. What is the current status of these regulations?

Answer. HCFA issued manual instructions implementing the OBRA 87 mental health provision in September 1988.

In drafting manual instructions and regulations to implement OBRA 89 we will not limit the settings in which beneficiaries are treated. We plan to issue operating manual instructions to the carriers to this effect within the next few months, and related regulations as soon as possible thereafter.

Question. On a related issue, in expanding the Medicare mental health benefit, Congress recognized the benefits of coordination and collaboration between mental

health professionals in treating Medicare beneficiaries. As a result, Congress required psychologists and clinical social workers to inform Medicare beneficiaries of the desirability of conferring with their primary care physician to determine if there are underlying medical complications contributing to their symptoms and to notify the primary care physician that mental health care is being provided to the patient, unless the patient specifically requests that the information not be shared. I would like to emphasize that HCFA should take particular care not to create additional access problems by drafting regulations that would, in anyway, make it more difficult for Medicare beneficiaries to receive needed mental health care. Can you comment on my concern?

Answer. While a collaborative process adds another dimension to the mental health care of a Medicare beneficiary, the implementing regulations will be developed to comply with congressional intent to improve coordination of overall health care without erecting barriers to such care.

Question. As you know, Congress enacted expansive nursing home reform legislation in 1987. One aspect of that legislation requires that every nursing home resident and applicant to a nursing home be evaluated and screened for mental illness to ensure appropriate nursing home placement and to guarantee that all residents get the mental health care that they need. I understand that these provisions are referred to as PASARR. HCFA is currently promulgating regulations to implement these provisions, and I have been told that draft HCFA guidelines would require that every mental health evaluation be validated by a board certified psychiatrist and that all mental health "active treatment" plans be provided under the supervision of a physician. In light of the access problems which led Congress to enact legislation that allows Medicare reimbursement for mental health services provided by psychologists and clinical social workers, I am concerned that HCFA is considering a different standard for PASARR purposes than the one legislated by Congress for Medicare. Can you comment on HCFA's proposed regulations for implementing PASARR?

Answer. The draft PASARR guidelines require that a physician or a board eligible or board certified psychiatrist approve a determination that a nursing home applicant or resident needs active treatment. This requirement was developed after consultation with many groups. We believe this professional expertise is absolutely necessary when deciding whether a person should be admitted to a nursing facility or other more appropriate setting.

We do not suggest that services must be provided by a physician or a psychiatrist, only that these critical determinations either be made by them or approved by them. We recognize that there is some controversy on whether this is a necessary requirement, and we are hoping to resolve this critical issue in the rulemaking process. Our proposed rule specifically seeks comment on the matter.

Responses by Dr. Wilensky of Questions From Senator Daschle

When Medicare beneficiaries elect hospice care, they waive eligibility for duplicative services related to their terminal illness. In other words, a hospice patient cannot use his Medicare eligibility to obtain both hospice care and, for example, home health care at the same time if both services relate to his terminal condition.

In 1986, Congress enacted the Medicaid Hospice Benefit which mirrors the Medicare Hospice Benefit in this regard. When a Medicaid beneficiary elects hospice care, hospice becomes the sole source of his terminal care, aside from his attending physician. Other Medicaid services not related to a patient's terminal illness can be obtained by such a patient, just as a Medicare hospice patient dying of cancer does not always waive his eligibility for Medicare part A hospital coverage in the case of a car accident.

However, I am told that in the administration of the Medicaid Hospice Benefit there are some problems with some States that require Medicaid hospice patients to waive eligibility for coverage of items which are either clearly unrelated to their terminal illness or which do not mirror duplicative services a Medicare hospice patient would waive.

For example, I understand that the State of New York requires Medicaid hospice beneficiaries to waive eligibility for attendant care, although there is no attendant care waived by Medicare hospice patients. I also understand that in Texas, Medicare hospice patients have been told they must give up eligibility for "meals on wheels" and primary caregiver services in order to obtain Medicaid coverage of hospice care.

The law is clear that the benefits a Medicaid patient waives to obtain hospice care should be the same benefits a Medicare patient waives to receive hospice care. The

inconsistency and confusion seems to be in the administration of the law and the varying interpretation that HCFA has allowed from case to case.

This present hospice patients with a critical dilemma, Particularly since the patients caught in this situation generally only have weeks to live.

I know you are sensitive to the fact that terminally ill patients who are in a hospice today need a prompt answer. Since this appears to be a problem with inconsistent application of the law, I hope this matter can be resolved administratively clarification is probably necessary, however, to ensure that hospice patients waive eligibility for those Medicaid services which are related to the patient's terminal condition and duplicative of those services a Medicare hospice patient would waive.

Therefore, I request that you review this matter as soon as possible and advise me on how you propose to address some of the inconsistencies in the administration of the hospice benefit.

I appreciate your attention to this request.

Answer. The law requires that both Medicare and Medicaid patients electing hospice care waive their right to other Medicare and Medicaid benefits to care for their terminal condition. The specific benefits waived may vary since State Medicaid programs may cover optional benefits not covered by Medicare.

Covered hospice services include nursing care, medical social services, physicians' services, counseling services, short-term inpatient services, medical appliances and supplies (including drugs and biologicals), home health aide services and homemaker services (home health aides may provide personal care services) and physical therapy, occupational therapy, and speech-language pathology services.

We believe that New York and Texas are correctly administering the law. In New York, "attendant care" basically means personal care services. In Texas, "primary caregiver services" generally are homemaker and personal care services. In both situations, these are covered hospice services and should be provided by the hospice. In addition, Texas requires that "meals on wheels" be waived when meal preparation is provided as part of the recipient's plan of care under the Medicaid hospice benefit.

RESPONSES BY DR. WILENSKY TO QUESTIONS FROM SENATOR DURENBERGER

Question. During the past three years, a large number of HMOs withdrew from the Medicare Prepaid Health Program. This has caused the growth of the Prepaid Program to level-off. I'd like to ensure that Medicare beneficiaries continue to have a choice of medical plans under this program. What is your level of commitment to the Prepaid Health Program and to managed care in general for Medicare beneficiaries?

Answer. In answering your question, I would first like to express my support for and commitment to managed care. I believe that managed care offers high quality care to Medicare beneficiaries through a coordinated delivery system which emphasizes prevention of illness.

Regarding your concern over the number of HMOs withdrawing from the Medicare risk-contract program in recent years, it is important to consider the size of the non-renewing plans.

For contract year 1990, 31 plans decided to nonrenew their Medicare contract. However, 27 of these plans had never enrolled any members, and the four remaining plans enrolled approximately 11,000 Medicare beneficiaries. So while the number of plans nonrenewing seems high, the number of beneficiaries affected is only 1.1 percent of the total enrollment in Medicare prepaid plans.

The number of Medicare beneficiaries enrolling in prepaid plans is increasing at a steady rate and the smaller plans participating in the Medicare program are consolidating. We think this trend toward stabilization is a favorable one.

There are two initiatives included in the 1991 budget proposals meant to encourage increased enrollment in Medicare HMOs and CMPs. The first proposal is one that would allow Medicare wrap around policies that incorporate preferred provider networks to be marketed as Medigap Policies. The second initiative would increase HMO/CMP payments to 100 percent of the AAPCC. Part of this increase would be provided directly to the beneficiary in the form of a partial rebate of their part B premium, and the remainder of the increase will be used by the plans for additional benefits or reduced plan premiums. I strongly support these proposals, as I believe they will encourage both the beneficiaries and the plans to participate in the Medicare prepaid health program.

Question. What is your sense of the overall direction of the U.S. health care system . . . do you think we are incrementally headed towards a social insurance model or towards a market-oriented model.

Answer. While we often hear calls for a social insurance approach to health care coverage, I do not think that the American society would ultimately support such a system. Our nation is steeped in the tradition of pluralism, capitalism, and an economy controlled by market forces. Existing "social" programs will continue to meet their obligations, but I do not believe that the health care system in our country is headed towards socialization. Most would agree that both the public and private sector need to share the burden of assuring that our nation's citizens are adequately insured for necessary health care coverage.

Question. Do you foresee a major role for the Federal government in assuring access to care for the uninsured and/or for financing a program of long-term care services for the elderly?

Answer. I share your concern that too many Americans do not have any or adequate health insurance coverage. I believe that we must work together to develop solutions to this problem. At this time, it is unclear what role the Federal Government should assume. The issue is under discussion as part of a Department task force chaired by the Under Secretary. I am Vice-chair of this task force. We are charged with preparing recommendations on the uninsured and long-term care. Among the options being explored to make health insurance more affordable are proposals to allow low-income, employed individuals to buy into Medicaid and encouraging States to develop State risk pools for those with serious pre-existing health conditions.

I also want to review the recommendations of the Pepper Commission and the Advisory Council on Social Security.

Question. I think I speak for many of my colleagues when I express concern about the current status of health care in rural America. The facts of this situation are well known. I'd like to know what direction you will set for HCFA in developing innovative approaches for the delivery and financing of health services in rural areas, which are distinct from basic issues of Medicare payment rates to rural hospitals and doctors.

Answer. I share your concern that access to necessary health care is preserved for our rural citizens. As you know, there are a number of programs underway to explore new approaches to rural health care delivery. Among these are the rural health transition grants, the Montana Medical Assistance Facility Demonstration, and the Texas Medical Education Demonstration. We are also developing an implementation strategy for the Essential Access Community Hospital/Rural Primary Care Hospital program for States and rural hospitals to establish rural networks or care providers. These programs will give us important information on how best to help rural areas maintain a health care capability. Congress has recently provided additional funding for the rural health transition grant program. This will provide more assistance to hospitals and their communities to modify services to meet market conditions.

Question. Last year, as part of the Physician Payment Reform Bill, the Congress created the Agency for Health Care Policy and Research, to develop "clinical practice guidelines." I'd be interested in hearing your views on whether the guidelines, once developed, should be related to Medicare coverage. For instance, do you foresee a time when Medicare coverage for some procedures would be denied because the procedure was not called for by any specific guideline?

Answer. At the outset, let me remind you that, since its inception, the Medicare program has not paid for services which are considered unnecessary or ineffective by the medical profession.

The primary goal of the Effectiveness Initiative is to provide better information on "what works" in the everyday practice of medicine to physicians and to patients. We believe that physicians, especially, are eager to have such valuable information and will voluntarily act on it. In this way, the Initiative will help ensure that the treatments we *do* pay for are effective, and that Medicare trust fund monies are well spent.

It is too early to determine whether the guidelines developed with outcomes information will be useful in making Medicare coverage decisions. It would seem likely, however, that the guidelines would provide helpful information to assist in making determinations.

Question. Dr. Wilensky, this question concerns implementation of the Physician Payment Reform Bill. I understand that there is some tension between the Physician Payment Review Commission and HHS over which organization is better qualified to develop certain important policies required to implement the new law. Recognizing that you served on the Commission, I would like to know what your views are about the respective roles of each organization in this process.

Answer. The Department, through HCFA, is directly responsible for implementing the Medicare physician payment reform package according to current law. HCFA has already begun the implementation process, including the development of ancillary policies.

The Physician Payment Review Commission is an advisory body, making recommendations to Congress on matters pertaining to physician payment reform.

Question. Dr. Wilensky, my office has received a lot of feedback from various health care manufacturers concerning the proposed "safe harbor" regulation which was issues by the Inspector General's Office. I hope you will be involved in the review of this regulation before it is finalized. Assuming that you will be, I have three questions.

First, concerning the section of the rule dealing with manufacturers' discounts, what can you do to assure that a reasonably broad scope of discount arrangements will be permissible under the final regulation?

Second, in addition to the proposed narrow safe harbors, do you plan to suggest criteria for a generic safe harbor, which would provide broader guidance for analyzing acceptable health care business practices?

Third, do you favor expanding the commissioned sales safe harbor to include sales personnel who are independent contractors?

Answer. I defer, of course, to the Inspector General on this issue. However, I will offer you my thoughts on these questions.

The intent of the law, as I understand it, is to prevent practices which encourage unwarranted increases in Medicare spending. To the extent that discounts benefit Medicare and Medicaid and do not promote unnecessary utilization, then we would generally be in favor them.

Second, generic safe harbors would not be consistent with the intent of the law. The task under the statute is to specify payment practices that will be permitted under Medicare and Medicaid. To permit a generic safe harbor such as "acceptable business practices" would be problematic. Further definition of "acceptable" would be necessary but difficult. In addition, practices that are acceptable in one economic area, may not be appropriate for the health sector which operates under somewhat different market forces.

Third, I would point out independent contractor personnel are not employees and should probably not be included in the safe harbor for commissioned sales.

COMMUNICATIONS

OFFICE OF GOVERNMENT ETHICS,
Washington, DC, November 21, 1989.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance,
U.S. Senate,
Washington, DC.

Dear Mr. Chairman: In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure-report filed by Martin H. Gerry, who has been nominated by President Bush for the position of Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

The report has been reviewed and advice obtained from the Department of Health and Human Services concerning any possible conflict in light of the Department's functions and the nominee's proposed duties. Based thereon, we believe Mr. Gerry is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

DONALD E. CAMPBELL, *Acting Director.*

OFFICE OF GOVERNMENT ETHICS,
Washington, DC, December 28, 1989.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance,
U.S. Senate,
Washington, DC.

Dear Mr. Chairman: In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Mr. Peter K. Nunez, who has been nominated by President Bush for the position of Assistant Secretary for Enforcement, Department of the Treasury.

We have reviewed the report and have also obtained advice from the Department of the Treasury concerning any possible conflict in light of its functions and the nominee's proposed duties. A copy of a letter from ethics officials at Treasury is enclosed.

Based on the foregoing, we believe that Mr. Nunez is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

DONALD E. CAMPBELL, *Acting Director.*

OFFICE OF GOVERNMENT ETHICS,
Washington, DC, November 17, 1989.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance,
U.S. Senate,
Washington, DC.

Dear Mr. Chairman: In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Mr. Abraham N.M. Shashy, Jr., who has been nominated by President Bush for the position of Assistant General Counsel, Department of the Treasury/Chief Counsel, Internal Revenue Service.

We have reviewed the report and have also obtained advice from the Department of the Treasury concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is a letter of November 14, 1989, from ethics officials at the Department of the Treasury, and an ethics agreement of November 7, 1989, from Mr. Shashy. His agreement indicates that upon confirmation he will withdraw from the law firm in which he is currently a partner (Jones, Day, Reavis, and Pogue); that he will recuse himself from participation in government matters where either that firm or his former law firm (Kronish, Lieb, Shainwit, Weiner and Hellman) are parties or represent a taxpayer; that he will recuse himself where any person or entity listed on his disclosure statement is a party or makes an appearance; that he will divest himself of all publicly traded and closely held securities and all partnership interests (other than his two real estate partnerships, Joy-An Associates and Montreal Ltd., with respect to which he will recuse himself) within 90 days of confirmation, and that, pending this divestiture, he will recuse himself from participating in matters affecting those entities or obtain appropriate agency waivers.

Based on the foregoing, we believe that Mr. Shashy will be in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

DONALD E. CAMPBELL, *Acting Director.*

OFFICE OF GOVERNMENT ETHICS,
Washington, DC, November 30, 1989.

Hon. LLOYD BENTSEN, *Chairman,*
Committee on Finance,
U.S. Senate,
Washington, DC.

Dear Mr. Chairman: In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Ms. Gail R. Wilensky, who has been nominated by President Bush to be the Administrator of the Health Care Financing Administration, Department of Health and Human Services (HHS).

We have reviewed the report and have also obtained advice from the Department of Health and Human Services concerning any possible conflict in light of its functions and the nominee's proposed duties. As noted in the enclosed letter to me from Ms. Sandra H. Shapiro, Alternate Designated Agency Ethics Official, HHS, Ms. Wilensky has agreed to resign from the four outside positions she currently holds, and to divest of her IBM stock and certain stock which she is likely to inherit from her mother's estate. She has agreed to recuse herself from participating in any matters involving these stocks, pending their divestiture, as well as certain other matters related to her prior employer and her spouse's medical practice. Finally, Ms. Wilensky has agreed to obtain a waiver pursuant to 18 U.S.C. section 208(b) as to certain financial interests related to her spouse's practice in order to enable her to participate in general policy, regulatory, and legislative matters.

Based thereon, we believe that Ms. Wilensky is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

DONALD E. CAMPBELL, *Acting Director.*

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